

**2 month - well child care**

**Patient Name:** \_\_\_\_\_ **D.O.B** \_\_\_\_\_

Please fill in the blank or check the appropriate answer as it pertains to your child.

**Household**

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? \_\_\_\_\_

Does your child attend daycare? \_\_\_\_\_  Yes  No

**Development**

Makes sounds other than crying \_\_\_\_\_  Yes  No

Reacts to loud sounds \_\_\_\_\_  Yes  No

Holds head up when on tummy \_\_\_\_\_  Yes  No

Moves both arms and legs \_\_\_\_\_  Yes  No

Opens hands briefly \_\_\_\_\_  Yes  No

Watches you as you move \_\_\_\_\_  Yes  No

Looks at a toy for several seconds \_\_\_\_\_  Yes  No

Calms when spoken to or picked up \_\_\_\_\_  Yes  No

Looks at your face \_\_\_\_\_  Yes  No

Seems happy to see you when you walk up to them \_\_\_\_\_  Yes  No

Smiles when you talk or smile at them \_\_\_\_\_  Yes  No

**Nutrition**

How is the baby fed? \_\_\_\_\_  Breast Fed  Formula \_\_\_\_\_

How much and how frequent? \_\_\_\_\_

If breastfeeding, is the baby receiving a vitamin D supplement?  Yes  No

Wakes for feeds overnight? \_\_\_\_\_  Yes  No

**Bowel habits**

How many stools does you child have per day? \_\_\_\_\_

What do the stools look like (soft, seedy, loose)? \_\_\_\_\_

**Sleep Pattern**

Sleeps on their back? \_\_\_\_\_  Yes  No

**Safety**

Is your child's car seat rear facing and in the back seat? \_\_\_\_\_  Yes  No

Is your child exposed to tobacco smoke? \_\_\_\_\_  Yes  No

Are there any improperly stored firearms in the home? \_\_\_\_\_  Yes  No

Is the hot water temperature set low enough  
to prevent accidental burns? \_\_\_\_\_  Yes  No

Are there working smoke detectors in the home? \_\_\_\_\_  Yes  No

**Please share any concerns that you have about your child here:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please complete both sides of this form*

**Please circle any of the questions below to which your answer is "YES".**

**Lead Risk Assessment:**

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

**Tuberculosis Risk Assessment:**

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

**Social Determinants of Health Assessment:**

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

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**Below this line is for Office Use:**

Weight \_\_\_\_\_

Height \_\_\_\_\_

Head Circumference \_\_\_\_\_

***Please complete both sides of this form***