Medical Record Number

Patient Name

Patient Label

Well Baby Check: 0-2 week visit questionnaire

Interval History:

Was your baby born full term (gestational age 37 weeks or more)?	Yes	No	
Were there any problems with the pregnancy or delivery?	No	Yes	
Has your baby had any illnesses, ER or Urgent Care visits since hospital discharge, or since last seen by us?	No	Yes	
Did your baby pass the hearing test done in the hospital?	Yes	No	Unsure
Did your baby have a Newborn Screen done in the hospital? (a test where blood is taken from the heel)	Yes	No	Unsure

Development:

Does your baby regard your face (starting to focus with his/her eyes)?	Yes	No	
Does your baby respond to voices or sounds?	Yes	No	
Does your baby move both arms and legs equally?	Yes	No	
Do you have any concerns about how your baby sees or hears?	No	Yes	

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always put your baby to sleep on her/his back?	Yes	No	
Do you always place your baby in a rear-facing car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your baby?	Yes	No	
Does your baby spend time with anyone who smokes?	No	Yes	

Parental Support:

During the past 2 weeks, how often have you been bothered by the following problems:

Feeling down, depressed, irritable, or hopeless?

[Not at all] [Several days] [More than half the days] [Nearly every day]

Little interest or pleasure in doing things?

[Not at all] [Several days] [More than half the days] [Nearly every day]

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Nutrition/Physical Activity:

What was your baby's birth weight? ___lbs____oz

For Breastfeeding: How many minutes of feeding per side? _____minutes

For formula/bottle feeding: How many ounces per feeding? _____oz

If you are giving formula, what brand are you using? _____

How often does your baby feed? Every_____hours

How many feedings in 24 hours? _____feedings

Do you give your baby a bottle of anything other than formula or breast milk? No Yes

Do you have any concerns about your baby's feeding/weight? No Yes Skip

Elimination:

Does your baby have at least 6-8 wet diapers in 24 hours? Yes No

Does your baby have a strong urine stream? Yes No Unsure

Does your baby have soft, yellow bowel movements? Yes No

Please list any medications or supplements your baby is taking, including vitamin D:

_____

Please list any major family medical issues:

_____

Please list any known Allergies:

_____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date: