2 Month Well Check-Up

Person completing form: Mother____Father_____Grandparent____ Other __________

Parental Concerns:
IF YES, please check the following items that apply:
feedings___; spitting up___; sleep issues___; constipation___;
colic___; nasal stuffiness___; others, please note below
____

Relationships:
Who lives in the home with the child?______________________________
Number of siblings? ____________
Are you coping well with your child? No____Yes____
Are you comfortable with your child? No____Yes____
Over the past 2 weeks, have you felt down, depressed or hopeless? No____Yes____

Smoking:
Are there any smokers at home? No____Yes____
If yes, who?____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? ___________________________

Home Environment :
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Home built before 1978 with renovations In the last 6 months? No____Yes____

Safety:
Infant car seat rear facing in vehicle? No____Yes____
Does your dwelling have:
Carbon monoxide detectors No____Yes____
Smoke detectors No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? ______________________
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Sleep Habits:
Any concerns? No____Yes____
If yes, explain____
Does your child take naps? No____Yes____
Does your child sleep in bed with parents? No____Yes____
Does your child sleep through the night? No____Yes____
Does your child sleep on their back? No____Yes____

Nutrition:
Any concerns? ____________________________________
Is your child on the WIC program? No____Yes____
Does your child get breast milk? No____Yes____
How often are they feeding? ______________
Does your child get formula? No____Yes____
What type? _____________________
How many ounces per feeding? ___________
How often? ______________

Elimination:
Any concerns about urine output? No____Yes____
Any concerns about bowel movements? No____Yes____

Illness/Injuries/Hospitalizations/Surgeries:
Since the last well visit, has your child:
been admitted to the hospital? No____Yes____
Had any surgery? No____Yes____
If yes, please explain ____________________________
____

Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe ______________________________
____
____

*****See back of form*****

Developmental Milestones

	Not At All	Somewhat	Very Much
Makes sounds that let you know he or she is happy or upset…	○	○	○
Seems happy to see you……..	○	○	○
Follows a moving toy with his or her eyes…..	○	○	○
Turns head to find the person who is talking…..	○	○	○
Holds head steady when being pulled up to a sitting position…	○	○	○
Brings hands together….	○	○	○
Laughs…..	○	○	○
Keeps head steady when held in a sitting position….	○	○	○
Makes sounds like "ga", "ma", or "ba"….	○	○	○
Looks when you call his or her name…	○	○	○