

Pediatric Health Maintenance: 2 or 4 Weeks Parent Questionnaire



Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health		<input type="checkbox"/> I'd like to discuss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will you be returning to work and/or will your child attend daycare?

Feeding and Sleeping		<input type="checkbox"/> I'd like to discuss
What is your baby fed? <input type="checkbox"/> Breastmilk <input type="checkbox"/> Formula (type):		
Ounces per feeding (if bottle fed):		
My baby feeds every _____ hours during daytime and is usually up _____ times during the night to feed.		
Where does your baby sleep? <input type="checkbox"/> Crib/bassinet <input type="checkbox"/> Parent's bed <input type="checkbox"/> Other		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you think your baby's bowel movements are normal?

Development		<input type="checkbox"/> I'd like to discuss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can your baby lift his or her head slightly when lying face down?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your baby move his or her arms and legs equally?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can you calm your baby?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your baby look at you briefly?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your baby respond to noise?

Safety		<input type="checkbox"/> I'd like to discuss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your home have functioning smoke detectors?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is your water heater turned down to below 120 degrees? <input type="checkbox"/> Don't Know
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your child ride in a rear-facing car seat, in the back seat?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you leave your baby alone on the changing table, sofa, or bed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are there any smokers in your home?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you afraid of your partner or anyone close to you?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 2-4 Weeks form.

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME & ID #