Pediatric Health Maintenance: 6-8 Weeks
Parent Questionnaire

Virginia Mason

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

General Health ☐ I'd like to discuss		
☐ Yes	☐ No	Will your child be in daycare or in the care of a babysitter?

Feeding and Sleeping ☐ I'd like to discuss		
What is your baby fed? ☐ Breastmilk ☐ 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.		
Any vitamins?	☐ No ☐ Vitamin D ☐ Other:	
Where does your baby sleep? ☐ Crib/bassinet ☐ Parent's bed ☐ Other		
☐ Yes	☐ No	Does your baby sleep on his or her back
☐ Yes	☐ No	Do you think your baby's bowel movements are normal?

Development ☐ I'd like to discuss		
☐ Yes	☐ No	Can your baby lift his or her head slightly when lying face down?
☐ Yes	☐ No	Can you calm your baby?
☐ Yes	☐ No	Does your baby smile at you?
☐ Yes	☐ No	Does your baby vocalize or coo spontaneously?
☐ Yes	☐ No	When you move a toy from side to side in front of your baby's face, does he or she follow the toy with their eyes?

Safety ☐ I'd like to discuss		
☐ Yes	☐ No	Does your home have functioning smoke detectors?
☐ Yes	☐ No	Is your water heater turned down to below 120 degrees? ☐ Don't Know
☐ Yes	☐ No	Does your child ride in a rear-facing car seat, in the back seat?
☐ Yes	☐ No	Do you leave your baby alone on the changing table, sofa, or bed?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ 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 6-8 Weeks form.

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME & ID #