Reedsburg AREA MEDICAL CENTER Physicians Group

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Patient Questionnaire – Two-Month Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic caregiver stress at home
Nutrition	
Milk Source (please circle)	Breastfeeding Cow's Milk Formula
Additional Intake (please circle)	Solids Water Non-nutritional
Breast Feeding	
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours
Side per Feeding (please circle)	One side Both sides
Feeding time per side (minutes) (please circle)	**Right breast:** 1-5 6-10 11-15 16-20 20+ **Left breast:** 1-5 6-10 11-15 16-20 20+ **Ounces per 24 hours:** _____

Please see reverse side

Breast Feeding Cont.	
Pumped (please circle)	Yes No
Formula	
Type of Formula (please circle)	Cow's milk based Low Iron Premature Extensively Hydrolyzed Metabolic Soy Lactose Free **Ounces per Feeding: _____** **Ounces per 24 hours: _____**
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours
Cereal	
Cereal Type (please circle)	Barley Corn Oat Rice
Feeding Problems (please circle)	Burping Poorly Spitting Up Vomiting
Elimination	
Urinary Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours With every feeding 1-3 times per 24 hours More than 6 times per 24 hours
Stool Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours Once per 48 hours 1-3 times per 24 hours With every feeding Once per 72 hours 4-6 times per 24 hours
Stool Consistency (please circle)	Formed Hard Loose Seedy Watery
Elimination Problems (please circle)	Colic Diarrhea Urinary Symptoms Constipation Gas

Sleep	
Sleep Location (please circle)	Bassinet Crib Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretaker's arms while feeding On own In caretaker's arms
Sleep Position (please circle)	Supine (on back) On side Prone (on stomach) **Average sleep duration in hours: _____**
Safety/Environment	
Home is child-proofed (please circle)	Yes No Partially
Smoking in home (please circle)	Yes No
Working smoke alarms (please circle)	Yes No Don't know
Working CO (carbon monoxide) alarms (please circle)	Yes No Don't know
Car seat (please circle)	Yes No
Screening	
Immunizations up-to-date (please circle)	Yes No
Neonatal screens normal (please circle)	Yes No
Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider
Days per week at daycare: _____ **Hours per day at daycare: _____**	

Please see reverse side

Growth and Development

Do you or your family have concerns about your baby's development or behavior? (please circle)

Yes No

Does your baby:

Smile at the sound of your voice or when smiled at? (please circle)

Yes No

Raise head when lying on tummy? (please circle)

Yes No

Respond to loud noises? (please circle)

Yes No

Follow moving objects with eyes? (please circle)

Yes No

Make sounds with voice? (please circle)

Yes No