Sutter Health

Well Child Check: 2 Month Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Can your child hold the head somewhat steady as you pick them up?	Yes	No	Unsure
Does your child hold objects briefly?	Yes	No	Unsure
Does your child follow you or objects with their eyes?	Yes	No	Unsure
Does your child look at objects?	Yes	No	Unsure
Does your child look at faces?	Yes	No	Unsure
Does your child smile?	Yes	No	Unsure
Does your child coo (make "ooh", "aah" sounds)?	Yes	No	Unsure

Does your baby drink breast milk or formula? Breastmilk Formula Both

If you are giving formula how many ounces does your child take in 24 hours? _____ oz.

Type of formula? _____

Do you always place your infant to sleep on the back?	Yes	No	
Does the baby always sleep in a crib or bassinet?	Yes	No	Unsure
Do you have working smoke alarms in your home?	Yes	No	Unsure
Are there smokers in your home?	No	Yes	Unsure
Do you have any safety concerns in your home?	No	Yes	Unsure
If so, what are your concerns? _____			
Over the past 2 weeks, has mom ever felt down, depressed, or hopeless?	No	Yes	Unsure
Over the past 2 weeks, has mom felt very little or no interest or pleasure in doing things?	No	Yes	Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

_____

Who provides daytime care for your child? _____

Do you have any concerns about your child's development, or any other concerns you would like to discuss? No Yes Unsure

If so, please describe: _____