Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 – No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

2 Month Well Baby Questionnaire

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

Office Use Only

WT: _____

HT: _____

OFC:_____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

Child's Name: _____Birth Date: _____

Do you have any concerns about your baby today? _____
Any allergies to medicine, latex, etc.? Yes / No. Which ones? _____
Has your baby had any surgeries? Yes / No. If yes, describe: _____
Has your child been hospitalized overnight? Yes / No. Is yes, why: _____
Is your baby on any medicine/ vitamins? Yes / No. Which ones/dose? _____

Health: Is your baby exhibiting any of the following symptoms?

Ear Pain / Ear Pulling	Yes / No. If yes, how long? _____	Fever	Yes / No. If yes, how long _____
Ear Drainage	Yes / No. If yes, how long? _____	Swelling	Yes / No. If yes, how long _____
Eye Drainage	Yes / No. If yes, how long? _____	Cough	Yes / No. If yes, how long _____
Decreased Appetite	Yes / No. If yes, how long? _____	Vomiting	Yes / No. If yes, how long _____
Constipation / Gas	Yes / No. If yes, how long? _____	Diarrhea	Yes / No. If yes, how long _____
Urinary Symptoms	Yes / No. If yes, how long? _____	Rash	Yes / No. If yes, how long _____
Sleep Problems	Yes / No. If yes, how long? _____	Joint Pain	Yes / No. If yes, how long _____

Nutrition/Elimination:

Breast Feeding Yes / No	**Formula Feeding Yes / No**
How often & how long? _____ Alternating sides each feeding? Yes / No. Pumping and using expressed breast milk (bottle)? Yes / No. Is mom on any medication or vitamin supplements? Yes / No. Which ones? _____	Which formula? _____ How many ounces & how often? _____ Circle your baby's water supply source: City Bottled Well.
Elimination	**Solids**
How many wet diapers per day? _____ How many stools per day? _____ Does your baby have a good urine stream? Yes / No.	Is your baby eating any solid foods? Yes / No. If yes, what kind? _____ How often? _____How much (ounces/ jars)? _____

Sleep:

How many hours does your baby sleep straight at night? _____
How many naps does your baby take each day? _____ Duration? _____

Social:

Any changes in your baby's environment? (new home, pets, daycare, etc.)_____
Is this child yours by: __ birth __ adoption __ marriage (stepchild) other _____
Who lives in the household with the child? (Please list for all households if more than one) **Please specify relationship to child**
_____
Marital status of Parents: __ married __ unmarried __ separated __ divorced __living together __ other: _____
Does this child live with you full-time? ____ Other? (Please describe)_____
Who is the primary caretaker in the home? _____
Does anyone in the household(s) smoke (inside or outside)? Yes / No. If yes, who? _____
Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____
Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____
Is your baby in daycare? Yes / No. If yes, where/who? _____
Any pets? Yes / No. Which kind/how many? _____
Any food allergies in your family? Yes / No. If yes, who and to what? _____
Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

This form completed by: _____ Relationship to Child: _____ Today's Date_____