**2 Week Well Baby Questionnaire**

*Office Use Only*

VFC: [ ] V02 -- MDD

 [ ] V03 – No Ins

 [ ] V04 -- Native

 [ ] V07 -- AVAP

INSURANCE:

 Copay / Co-ins

Statement Balance

*Office Use Only*WT: \_\_\_\_\_\_\_kg \_\_\_\_\_\_\_lb

TEMP:\_\_\_\_\_\_\_ OFC:\_\_\_\_\_\_

Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TECH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. If your child requires significant medical intervention 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.

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any concerns about your baby today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Is your baby on any medicine? Yes / No. Which ones/dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth History/Delivery**

Full term or premature (please circle) If premature, how many weeks early. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaginal or Cesarean (please circle)
Head first or breech delivery (please circle) Any complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forceps or vacuum used (please circle) Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Decreased Appetite Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fever Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_

Ear Drainage Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Rash Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_

Eye Drainage Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Constipation / Gas Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_

 **Nutrition**

|  |  |
| --- | --- |
| **Breast Feeding Yes / No** | **Formula Feeding Yes / No** |
| How often & how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is mom on any medication or vitamin supplements? Yes / No.  Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Which formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many ounces & how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Do you have any questions or concerns you would like to discuss with the Certified Breast Feeding Specialist? Yes/No
Is your baby on vitamins? Yes / No. If yes, which brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle your baby’s water supply source: City Bottled Well.

 **Social**Any changes in your baby’s environment? (new home, pets, daycare, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the household with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary caretaker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the family smoke? Yes / No. If yes, who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Mom working? Yes / No. Full Time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Dad working? Yes / No. Full Time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby in daycare? Yes / No. If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? Yes / No. If yes, which kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Development**Do you have any developmental concerns about your baby’s development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your baby:

Respond to loud noises? Yes / No. | Briefly lift head when lying on tummy? Yes / No. | Move all extremities equally? Yes / No.

 **Sleep and Elimination**

How many hours does your baby sleep straight at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many naps does your baby take each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many wet diapers per day? \_\_\_\_\_\_\_\_ How many stools? \_\_\_\_\_\_\_\_ Does your baby have a good urine stream? Yes / No.

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**