2 Month Health Maintenance Form

Patient Name _____

Who accompanied child today?
(name and relationship to child) _____

Who does child live with? _____

Any major health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Breastfeeding:

How long do feedings last? _____

How many hours between feedings in the day? _____

How many hours between feedings in the night? _____

Is your baby still taking Vitamin D supplement? Yes No

Bottle Feeding:

How many ounces per feeding? _____

How many hours between feedings in the day? _____

How many hours between feedings in the night? _____

Brand of formula used? _____

Any juices or solids started? _____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Any concerns with stooling or urination? _____

Is your child attending out of the home Child care? Yes No

Sleep pattern:

Average number hours of sleep in 24 hours: _____

Frequency of nighttime awakenings: _____

Number of naps: _____

Length of naps: _____

Where does your child sleep? _____

Are there any smokers at home or daycare? _____

Medications:

Please list current medications: _____

_____

_____

Any allergies to medicine? _____

_____

Does your baby:

Lift his/her head to 45 degrees when on tummy?	Yes	No
Smile?	Yes	No
Coo or vocalize?	Yes	No
Grasp items such as a rattle or finger?	Yes	No
Respond to noise?	Yes	No
Recognize/respond to faces, especially parents?	Yes	No
Follow you with his/her eyes, at least to the midline?	Yes	No

If you do not understand any of these questions, please ask your nurse.