2 Week Health Maintenance Form

Patient Name _____

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

If Breastfeeding:
Average time it takes to breastfeed between both breasts? _____

How many hours between feedings during the day? _____

How many hours between feedings during the night? _____

Longest time between feedings?
(in hours) _____

Average number of feedings in 24 hours? _____

Any supplementation of infant? Yes No

If yes, what is being given and how much? _____

Any discomfort or complications with feeds? _____

If Bottlefeeding:
Brand of formula used? _____

Average number of ounces per bottle? _____

How many hours between feedings during the day? _____

How many hours between feedings during the night? _____

Longest time between feedings?
(in hours) _____

Turn Over Please

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

Does your child or any household member Drink water from a private well? (consider vacation homes, relative's or friend's homes, daycare or school) Yes No

Elimination:

Average number of wet diapers per day? _____

Average number of stools per day? _____

Sleep Pattern:

Average number of hours of sleep in 24 hours? _____

Average number of night time awakenings? _____

Current Concerns? _____

_____

Medications:

Current medications? _____

_____

_____

Any medication allergies? _____

_____

For Mom:

Your mental health is important to your child's health. Over the past 2 weeks:

1. Have you ever felt down, depressed or hopeless? Yes No

2. Have you felt little interest or pleasure in doing things? Yes No

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