



2 Month Health Maintenance Questionnaire

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?

Feedings:

Breastfeeding:

How long do feedings last?

How many hours between feedings in the day?

How many hours between feedings in the night?

Bottle Feeding:

How many ounces per feeding?

How many hours between feedings in the day?

How many hours between feedings in the night?

Type of formula used?

Any juices or solids started?

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?

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.