



## 2 Week Health Maintenance Questionnaire

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:**

Formula type? \_\_\_\_\_

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) \_\_\_\_\_

*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?

\_\_\_\_\_

\_\_\_\_\_

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.***