



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) _____

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?

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