



Well Child Health Screen: 0-2 Months

Name: _____ Birthdate: _____ Visit Date: _____

General Health Updates

| | |
|---|--|
| Who is completing this form? | <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other, please list: |
| Any questions, concerns, or problems you want to discuss today? | |
| Any updates to the patient's health? (i.e. new conditions, surgeries, etc.) | |
| Any family health, family status or social updates we should be aware of? | |
| Any concerns about development, learning or behavior? | |
| Who lives with the patient? | |
| Any smoke or e-cigarette exposure? | |
| Anything else you want to share? (milestones, proud moments, etc.) | |

Development

The following section is used to make sure they are developing normally. Each set of milestones is generally achievable by 75% of children of the same age. If you have questions/concerns, please talk to your provider.

| | |
|---|---|
| If they are nearest 2 weeks , check the items they can do most of the time: | <input type="checkbox"/> Moves all extremities <input type="checkbox"/> Responds to sounds <input type="checkbox"/> Pays attention to your face |
| If they are nearest 4 weeks , check the items they can do most of the time: | <input type="checkbox"/> Responds to sounds <input type="checkbox"/> Lifts head when on tummy <input type="checkbox"/> Follows you with their eyes <input type="checkbox"/> Smiles in response to you <input type="checkbox"/> Makes noises other than crying |
| If they are nearest 2 months , check the items they can do most of the time: | <input type="checkbox"/> Makes sounds that let you know they are happy or upset <input type="checkbox"/> Reacts to loud sounds <input type="checkbox"/> Moves both arms and both legs <input type="checkbox"/> Watches you as you move <input type="checkbox"/> Opens hands briefly |

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

| | |
|--|--|
| Do you have concerns about their eyes or vision? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have concerns about their hearing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Well Child Health Screen: 0-2 Months

Family Life

Does anyone in the home/family have problems with drugs or alcohol? Yes No Decline

Nutrition

What are they eating? Breastmilk Formula Both
 Other, describe:

Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

Where do they sleep? Crib Bed Co-sleep
 Other:

Do you put them to sleep on their back? Yes No

Safety

Is the baby riding in a rear-facing car safety seat in the backseat every time in a vehicle? Yes No
