Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

2 Month Old Parent Observations

Are there any concerns you would like to discuss today?_____

_____

Feedings:

Any concerns about feedings? Yes No

Are you breastfeeding? Yes No If yes, are you giving Vitamin D drops? Yes No

If bottle feeding: ☐ Pumped Breastmilk ☐ Formula (Name:_____)

How many bottles in 24 hours? _____ #of ounces per bottle: _____

Does your child spit up very often, forcefully, or with discomfort? Yes No

Voiding/Stooling:

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) Yes No

Quality of stools: ☐ Liquidy/Seedy ☐ Soft/Mushy ☐ Hard pellets/Logs

Sleep:

Any concerns about sleep? Yes No

Is your child sleeping on his/her back? Yes No

How many uninterrupted hours of sleep at night (i.e. in between feeds)? _____

How many naps per day? _____ How long is each nap? _____

Is your child sleeping in a: ☐ Bassinet ☐ Crib ☐ Co-Sleeping in bed with parent

Development:

Are you doing tummy time daily with your child? Yes No

Do you have any concerns about your child's hearing or vision? Yes No

Does your child: (please check all that apply)

☐ lift his/her head 45° above surface ☐ have head control when held upright

☐ react/turn to noise ☐ make cooing sounds

☐ follow with eyes to midline ☐ smile

☐ grasp an object placed in hand ☐ have differentiated types of crying

Social:

If parents plan to return to work, who will be caring for your child? _____

Are family members and siblings (if any) doing well with the baby? Yes No

Safety/Preventative Health:

Does your baby use a rear-facing care seat 100% of the time? Yes No

Do all family members buckle up with seat belts? Yes No

Is your home/car a smoke-free environment? Yes No

Any recent illnesses or fevers in last 24 hours? Yes No

Any questions or concerns about immunizations? Yes No

Please list any medications or supplements your child took this week: _____

_____