wasatch pediatrics | ST. MARK'S

PT ID: ___________________
PCP: ___________________
Today's Date: ____________

Patient's Name: _________________________
Date of Birth: ___________________________

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: (check all that apply)
☐ lift his/her head 45° above surface
☐ react/turn to noise
☐ follow with eyes to midline
☐ grasp an object placed in hand
☐ have head control when held upright
☐ make cooing sounds
☐ smile
☐ have differentiated types of crying

Social:
If parent(s) 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 child use a rear-facing car 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 the last 24 hours? .... YES NO
Any questions or concerns about immunizations? ....YES NO
Please list any medications or supplements you child took this week: ______________________________