OBERLIN ROAD PEDIATRICS

Well Child Check: 2 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes: _____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Nutrition:

Does you baby drink breastmilk, iron fortified formula, or both? □ Breastmilk □ Formula □ Both

If you are giving your baby bottles, how many ounces does your child take in 24 hours? _____

Development: Does your child……

Calm down when spoken to or picked up?	Yes	No
Look at your face?	Yes	No
Smile when you talk to or smile at him?	Yes	No
Make sounds other than crying?	Yes	No
React to loud noises?	Yes	No
Watch you as you move?	Yes	No
Look at a toy for a few seconds?	Yes	No
Hold head up when on her tummy?	Yes	No
Move both arms and legs?	Yes	No
Open his hands briefly?	Yes	No

Social update:

Who lives at home with your child? _____

Are parents: single married divorced separated

Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life? □ No □ Yes: _____

Do you always place your infant to sleep on the back?	Yes	No
Does the baby always sleep in a crib or bassinet?	Yes	No
Do you have working smoke alarms in your home?	Yes	No
Does anyone smoke or vape in your home?	No	Yes
Are you comfortable and confident in your abilities as a parent?	Yes	No
Is your baby beginning to develop regular sleep pattens?	Yes	No
Is a TV, computer, or tablet on in the background when your baby is in the room?	No	Yes
Do you put your baby on her tummy for short periods of time when she is awake?	Yes	No
Do you have ways to calm your baby when he is crying?	Yes	No
Do you have arrangements for childcare if you go back to work?	Yes	No
If yes, are you comfortable with them?	Yes	No
Is your baby fastened securely in a rear facing car seat in the back seat every time they ride in the car?	Yes	No
Is your water heater set so the temperature is at or below 120 degrees F?	Yes	No
Do you always stay within arm's reach of you baby when on the changer, bed or in/near water?	Yes	No
Do you have concerns about feeding your baby?	No	Yes
Have you had your 6 week check up? (Moms)	Yes	No
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never