Name: _____ Date of birth: _____

Health Status Questionnaire – 2 Months

Baby lives with: mother father both parents other:_____

Planned childcare: daycare babysitter stays at home other:_____

Breastfeeding? Y N Every ____ hours For _____ minutes per side

Formula feeding? Y N Formula:_____ ___ oz every ___ hours

If at least ½ the feedings are breastmilk, giving vitamin D supplement? Y N

Any problems feeding? Y N _____

Stool pattern: regular irregular hard runny soft

Place infant to sleep on back? Y N

Sleep problems: Y N _____

Does your baby:

Lift his/her head when laying on tummy?	Y	N
Have equal movements of both sides of body?	Y	N
follow object with eyes?	Y	N
vocalize/coos (“ooh” “aah” sounds)	Y	N
respond to stimuli?	Y	N
smile spontaneously?	Y	N
look at your face?	Y	N

Passive smoke exposure: Y N Car seat use: Y N

Smoke detectors: Y N Fire extinguishers: Y N

Do you have any concerns about your baby? _____

_____

Updated 8/28/17