2 month Well Child Check Name____

Allergies______________________Current Medications____

Is your baby healthy? **Yes** **No**_____________________________

Do you feel your baby is developing normally? Yes No_____________________________

Do you think your baby can hear? Yes No_____________________________

Do you think your baby can see? Yes No_____________________________

Does your baby have normal stools? Yes No_____________________________

Does your baby sleep a 3-4 hour stretch at night? Yes No_____________________________

If breastfeeding—are you having any problems? **No** **Yes**_____________________________

How often is your baby nursing? _____________________________________

If formula feeding—Type of formula? _____________________________________

How many ounces/how often? _____________________________________

Does your baby take a vitamin or supplement? **Yes** **No**

Are you feeling depressed or "down" much of the time? No Yes_____________________________

Has there been any recent change to your family structure? No Yes_____________________________

Is your baby in childcare? No Yes_____________________________

Does anyone in your household smoke ? No Yes

Where does your baby sleep? _____________________________________

Does your baby get daily tummy time? Yes No

Did you get your baby's 2nd PKU? Yes No

Do you have any other concerns?____

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Development (Do not complete if given Ages and Stages Questionnaire)

Does your baby coo?	Yes	No
Does your baby respond to your voice?	Yes	No
Does your baby show interest in sound or bright colors?	Yes	No
Do your baby's eyes cross?	Yes	No
Does your baby smile at you?	Yes	No
Is your baby able to lift his/her neck and chest when on his/her tummy?	Yes	No
When your baby is laying at rest on his/her back, are her/his hands open?	Yes	No
Is your baby able to hold his/her head up when upright?	Yes	No
Does your baby stop crying when talked to?	Yes	No
Does your baby grasp a rattle that is placed in his/her hand?	Yes	No