OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

Well-check questionnaire

2 month well-check

Patient name: ________________________ **DOB:** ____________________ **Today's date:** ________________

Medications: ____________________________________ **Allergies:** ___________________________________

Mother's maiden name: ____

Are you breast or formula feeding? ____

Name of formula: ________________________________ Ounces per feeding: ___________________________

Of wet diapers a day: ____________________________ # Of stools a day: _____________________________

Question		
Do you have any concerns with feedings?	☐ No	☐ Yes
Do you have a strong family history of food allergies?	☐ No	☐ Yes
Do you have concerns with your baby's bowel movements?	☐ No	☐ Yes
Do you have concerns with your baby's sleep habits?	☐ No	☐ Yes
Does your baby sleep in a crib or bassinet?	☐ No	☐ Yes
Have you been unusually sad or depressed since your baby's birth?	☐ No	☐ Yes
Do you plan to return to work or school?	☐ No	☐ Yes
Does/will your baby go to a daycare home or center?	☐ No	☐ Yes
Does your baby sleep on his/her back?	☐ No	☐ Yes
Are there pillows or loose bedding in your baby's crib?	☐ No	☐ Yes
Is your baby always in a car seat when riding in a vehicle?	☐ No	☐ Yes
Is your hot water heater turned down to 120?	☐ No	☐ Yes
Does your home have smoke and carbon monoxide detectors?	☐ No	☐ Yes
Is your baby exposed to second hand smoke at home, in cars or at daycare?	☐ No	☐ Yes
Are there any pets in the home?	☐ No	☐ Yes

Does your baby:

Question		
Coo or make soft, happy sounds?	☐ No	☐ Yes
Smile at faces or objects?	☐ No	☐ Yes
Respond to voices or sounds?	☐ No	☐ Yes
Lift his/her head when on stomach?	☐ No	☐ Yes
Move his/her arms and legs equally on both sides?	☐ No	☐ Yes

Is your baby:

Question		
Quick to agitation?	☐ No	☐ Yes
Difficult to soothe?	☐ No	☐ Yes
Irritable with feedings?	☐ No	☐ Yes

Any questions or concerns: ____

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