

2 Month Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1. Do you have any concerns about your baby?	NO	YES
2. Crying longer than 30 minutes at a time?	NO	YES
3. Skin color or skin rash concerns?	NO	YES
4. Severe nasal congestion?	NO	YES
5. Wheezing?	NO	YES

Feeding/Nutrition

6. Is your child breastfeeding well?	YES	NO
a. How often?		
b. For how long? (minutes)		
7. Is your child taking formula well?	YES	NO
a. How often?		
b. How many ounces?		
c. Which formula?		
8. Are you feeding your baby anything other than breastmilk or formula?	NO	YES
9. Is your baby taking a vitamin supplement?	YES	NO

Elimination

10. Problems with bowel movements (pooping)?	NO	YES
11. Urinating (peeing) well?	YES	NO

Sleep

12. Sleeps five or more hours at a time?	YES	NO
13. Questions about sleep habits?	NO	YES

Social Stressors

14. Siblings adjusting well to baby?	YES	NO
15. Has mother been sad or crying a lot? Feeling down, depressed, or hopeless?	NO	YES
16. Are you having family stress?	NO	YES
17. Do you ever worry your family will go hungry?	NO	YES
18. Do you have daycare concerns?	NO	YES

Development

19. Baby smiles at the sound of parent's voice?	YES	NO
20. Makes cooing noises?	YES	NO
21. Watches parent walk across the room?	YES	NO
22. Briefly holds objects when placed in the hand?	YES	NO
23. Raises head and chest when lying on tummy?	YES	NO

Safety

24. Is baby swaddled when sleeping?	NO	YES
25. Infant sleeps on his/her back?	YES	NO

26. Infant sleeps in a bassinet or crib, not in parents' bed?	YES	NO
27. Do you always keep a hand on baby when placed above the floor?	YES	NO
28. Does baby wear any jewelry (including necklaces)?	NO	YES
29. Is your infant exposed to anyone who smokes?	NO	YES
30. Home has working smoke detectors and carbon monoxide detectors?	YES	NO
31. Do you hold or carry hot liquids around the baby?	NO	YES
32. Do you keep plastic bags and latex balloons away from your baby?	YES	NO
33. Infant rides in a rear-facing safety seat, in the back seat?	YES	NO

Tuberculosis

34. Has a family member or contact had tuberculosis disease?	NO	YES
35. Has a family member had a positive TB skin test (PPD)?	NO	YES
36. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
37. Has your child traveled to a high-risk country for more than a week?	NO	YES