

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 1/2 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? _____