CHILDREN FIRST
DUMFRIES PEDIATRICS

Well Child Check: Newborn/2 Week Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Does your child lift the head?	Yes	No	Unsure
Does your child move arms equally and legs equally?	Yes	No	Unsure
Does your child seem to look at faces, objects or lights?	Yes	No	Unsure
Does your baby drink breast milk or formula?	Breast milk	Formula	Both

If you are giving formula how many ounces does your child take in 24 hours?_____ oz.

Type of formula?

_____

About how many wet diapers has your baby had in the last 24 hours? _____

About how many times has your baby pooped in the last 24 hours? _____ What Color?_____

Are you interested in seeing a lactation specialist?	Yes	No	Unsure
Do you always place your infant to sleep on the back?	Yes	No	Unsure
Does the baby always sleep in a crib or bassinet?	Yes	No	Unsure
Do you have working smoke alarms in your home?	Yes	No	Unsure
Are there smokers in your home?	No	Yes	Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

_____

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?

If so, please describe:

_____

_____