CASTLE VALLEY CHILDREN'S CLINIC
HEALTH MAINTENANCE VISIT
NEWBORN-2 MONTHS

Patient name: _____

PREGNANCY AND BIRTH

1. ***Did you have any illness or take any medication/drugs during pregnancy?..... YES NO***
2. ***Did you carry your baby for a full nine months?.....YES NO***
3. ***Baby's birth weight?*** _____
4. ***Did your baby have any problems while in the hospital? .....YES NO***

NUTRITION

5. ***Do you breast feed or bottle feed your baby?.....Breast Bottle***
6. ***How many times a day (24 HRS) does your baby breastfeed or take a bottle?*** _____
7. ***If bottle feeding, how many ounces does your baby drink each feeding?*** _____
8. ***If bottle feeding, what kind of formula do you use?*** _____
9. ***Does your baby take any other kinds of fluids besides milk? ..... YES NO***
10. ***Is your baby on cereal or baby foods? ..... YES NO***
11. ***Are you giving your baby vitamins, iron, or fluoride drops?..... YES NO***
12. ***Is your baby having any problems with feeding? ..... YES NO***

ELIMINATION

13. ***How many bowel movements (stools) does your baby have in a 24 hour period?*** _____
14. ***Are the stools: (circle) Watery? Soft and pasty? Formed? Like hard pellets?***

BEHAVIOR

15. ***Does your baby have any problems with sleeping?..... YES NO***
16. ***All babies cry. How much does your baby cry? (check) ___Very Little ____Some ____ A lot***
17. ***Is there anything that upsets you or concerns you about your baby?.....YES NO***
18. ***Do you feel you have a difficult child?.....YES NO***

DEVELOPMENT

Children learn different things as they grow. At this point in your child's development, which of the following can he/she do? (Please Check)

_____ ***Smiles*** _____ ***Make noises besides crying*** _____ ***Lifts up head while on stomach***
_____ ***Follows your movements by turning head from one side almost all the way to the other.***

ILLNESSES

19. ***Has your baby had any illnesses or needed to see a Doctor since birth? ..... YES NO***
20. ***Is your baby on any medications?..... YES NO***

REVIEW OF SYSTEMS (Check if your child has had any of the following:)

____ ***Convulsion or seizure*** ____ ***Crossed Eyes*** ____ ***Difficulty finishing a feeding*** ____ ***Eye drainage***
____ ***Head Injury*** ____ ***Stuffy nose*** ____ ***High Fever*** ____ ***Recent change in home/family***
____ ***Ear infection/earache*** ____ ***Trouble Breathing*** ____ ***Skin Rash*** ____ ***Turning blue***

Any question you have for us? _____