***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***

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

***ELIMINATION***

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

***BEHAVIOR***

1. ***Does your baby have any problems with sleeping?................................................... YES NO***
2. ***All babies cry. How much does your baby cry? (check) \_\_\_Very Little \_\_\_\_Some \_\_\_\_ A lot***
3. ***Is there anything that upsets you or concerns you about your baby?........................YES NO***
4. ***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***

1. ***Has your baby had any illnesses or needed to see a Doctor since birth? ……………… YES NO***
2. ***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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***