2 Month Health Questionnaire

IMPRINT AREA

This information is confidential.

Your answers help your physician or nurse practitioner choose the best topics to discuss with you at this visit. Skip any questions you don't understand or do not apply.

Phone:

What Things About Being A Parent Are Difficult For You ? Do You Have Any Questions or Concerns?

#	Question		
1.	Do you feed your baby breastmilk?	❒ No	❒ Yes
2.	Do you feed your baby infant formula with iron?	❒ No	❒ Yes
3.	Do you feed your baby anything besides breastmilk or formula?	❒ Yes	❒ No
4.	Do you always place your baby on his or her back to sleep?	❒ No	❒ Yes
5.	Do you place your baby in a car seat facing backwards, in the back seat?	❒ No	❒ Yes
6.	If you carry your baby in an infant seat or carrier, do you always put the seat on the ground and fasten the belt (so your baby won't fall out)?	❒ No	❒ Yes
7.	Have you turned your water heater temperature down to low/warm (less than 120°F)?	❒ No	❒ Yes
8.	Do you have smoke detectors in your home, and do you check them regularly?	❒ No	❒ Yes
9.	Have you checked your baby's toys to make sure they can't cause injury?	❒ No	❒ Yes
10.	Do you ever drink hot liquids while holding your baby?	❒ Yes	❒ No
11.	Do you ever leave your baby alone at home or in a car?	❒ Yes	❒ No
12.	Does your baby spend time in a home where anyone smokes?	❒ Yes	❒ No
13.	Since your last well check, have there been any MAJOR illnesses, hospitalizations, changes, or stresses for your family or baby? If yes, please list:	❒ Yes	❒ No
14.	Please list any medications your baby is taking:		
15.	Do you often feel sad, depressed, or blue?	❒ Yes	❒ No
16.	Do you put your baby to sleep when he or she is drowsy but still awake?	❒ No	❒ Yes
17.	Can your baby lift his or her head when lying on the tummy?	❒ No	❒ Yes
18.	Does your baby follow your face with his or her eyes?	❒ No	❒ Yes
19.	Does your baby coo?	❒ No	❒ Yes
20.	Does your baby smile at you?	❒ No	❒ Yes
21.	Do you cuddle and talk to your baby every day?	❒ No	❒ Yes
22.	Do you shake your baby when angry or frustrated?	❒ Yes	❒ No
23.	Is your baby in day care? Who else takes care of your baby?	❒ Yes	❒ No
24.	Did you read the vaccine information sheets?	❒ No	❒ Yes
25.	Has your baby ever had a reaction to a vaccine (such as a high fever)?	❒ Yes	❒ No

Clinic Counseling

❒ Questionnaire Reviewed

❒ Pertinent Topics Discussed and Advice Given

Sign: ________________

Parent Signature: ______________________________ Date: ______________

00248-003 (REV. 6-03) Bright Systems® Copyright ©The Permanente Medical Group, Inc. Northern California Regional Health Education