2 Month Visit

Patient Name	Date

Are you concerned about your baby's…..		
1. feedings?	YES	NO
2. excessive spitting or vomiting?	YES	NO
3. bowel movements?	YES	NO
4. nasal stuffiness, congestion or wheezing?	YES	NO
5. skin color, rashes or lesions?	YES	NO
6. excessive crying?	YES	NO
7. sleep habits?	YES	NO

Does your child….		
1. sleep on his or her back?	YES	NO
2. startle to loud noises?	YES	NO
3. hold head upright for a short time?	YES	NO
4. smile at the sound of your voice or seeing your face?	YES	NO
5. ride in a rear facing car seat?	YES	NO
6. use a pacifier?		
7. Do you know CPR?	YES	NO
8. Is smoking PROHIBITED in your house?	YES	NO
9. Do you wear your seat belt in the car?	YES	NO
10. Do you avoid drinking hot liquids near your baby?	YES	NO

Do you have other concerns you would like to discuss at your baby's visit?

OFFICE USE ONLY

WT	HT	HC	TEMP