Two Week Parent Questionnaire

Please complete this side only

Interval History/New Problems

Has there been any change in general family history since last visit? ❑ yes ❑ no
If "yes", please specify:

Any changes at home since last visit? ❑ yes ❑ no
If "yes", please specify:

General

Do you have any concerns or worries about your baby? ❑ yes ❑ no
If "yes", please specify:

Will you be returning to work? ❑ yes ❑ no
If 'yes', who will be caring for your child when at work?

Feeding

How is your baby fed?
❑ Breast ❑ Bottle: ❑ Expressed breast milk ❑ Formula: Name of formula _____ Ounces per feeding: _____
My baby feeds every _____ hours during the day and is usually up _____ times during the night to feed.

Sleep

Where does your baby sleep: ❑ Crib/bassinet/co-sleeper ❑ Parents' bed ❑ Other _____
Does your baby sleep on his/her back? ❑ yes ❑ no

Elimination

Do you think your baby's bowel movements are normal? ❑ yes ❑ no

Development

Do you have concerns about your baby's development or behavior? ❑ yes ❑ no
If "yes", please specify:

Does your baby respond to sound? ❑ yes ❑ no
Did your baby pass the newborn hearing screen? ❑ yes ❑ no
If "no", do you have repeat hearing screen scheduled? ❑ yes ❑ no
Does your baby look at your face? ❑ yes ❑ no
Does your baby move his/her arms and legs equally? ❑ yes ❑ no
Can your baby lift his/her head when lying face down? ❑ yes ❑ no
Can you calm your baby? ❑ yes ❑ no

Safety

Does your home have working smoke detectors? ❑ yes ❑ no
Is your water heater turned down to below 120 degrees? ❑ yes ❑ no
Does your child ride in a rear-facing car seat in the back seat? ❑ yes ❑ no
Does anyone smoke who cares for your child? ❑ yes ❑ no
Are you afraid of your partner or anyone close to you? ❑ yes ❑ no
Have you blamed yourself unnecessarily when things went wrong? Circle one: Yes, most of time Yes, some of time No, not often
Have you felt scared or panicky for no good reason? Circle one: Yes, most of time Yes, some of time No, not often
Have you been anxious or worried for no good reason? Circle one: Yes, most of time Yes, some of time No, not often

Completed by: _____ Relationship to Patient: _____ Date: _____

Provider review_____:

End of parent questionnaire

Patient Name: _____ DOB: _____