UW Medicine
UW NEIGHBORHOOD CLINICS

Two Week Old Well Child Visit

Baby's Name ______________________ Baby's Birth Date ______________

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Perinatal Issues (if this is 1st visit)	**Yes**	**No**
Was your baby born on time?	( )	( )
Number of weeks pregnant on day of birth?	( )	( )
Birth weight?		
Was it a vaginal delivery?	( )	( )
Passed hearing screen?	( )	( )
Were pregnancy, labor & delivery complication-free (examples: pre-eclampsia, high blood pressure, diabetes, abnormal ultrasound, emergency delivery)?	( )	( )
Was your baby head-down at the time of delivery?	( )	( )
Was your baby discharged home without problems, such as jaundice?		
Was the pregnancy free of alcohol, smoking, and other drugs?	( )	( )

Review of Nutrition	**Yes**	**No**
Is your baby being breastfed exclusively?	( )	( )
Is your baby feeding well?	( )	( )
How often is your baby feeding?		
How long/How many ounces?		
Is your baby stooling comfortably?	( )	( )
Is your baby making 6 or more wet diapers per day?	( )	( )

Social Screening	**Yes**	**No**
Is the family doing well, with stable housing? If no, please list specific stress or problem:	( )	( )
Long-term child-care plan in place?	( )	( )
Is your mood good overall?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Do you have a thermometer?	( )	( )
Does your baby sleep on her/his back/side?	( )	( )
Is your baby in a car seat in the backseat facing backwards when in the car?	( )	( )

Developmental Screening	**Yes**	**No**
Does your baby appear to respond to sounds?	( )	( )
Does your baby appear to follow faces or objects with her/his eyes?	( )	( )
Does your baby lift her/his head for a moment while on her/his stomach?	( )	( )
Does your baby move all four of her/his arms and legs equally	( )	( )

Current concerns not listed above:

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