Well Child Check:
2 Month Visit

marinhealth Medical Network | UCSF Health

Childs Name: _____ DOB: _____ Date: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues.

Can your child hold his/her head somewhat steady as you pick them up?	YES	NO	UNSURE
Does your child hold an object briefly?	YES	NO	UNSURE
Does your child seem to look at faces?	YES	NO	UNSURE
Does your child seem to look at objects?	YES	NO	UNSURE
Can your child follow you or objects with his/her eyes?	YES	NO	UNSURE
Does your child smile?	YES	NO	UNSURE
Does your child coo (make “ooh” or “ahh”) sounds?	YES	NO	UNSURE
Do you always place your infant to sleep on the back?	YES	NO	UNSURE
Does your baby sleep in a crib or bassinet?	YES	NO	UNSURE
Do you have working smoke alarms in your home?	YES	NO	UNSURE
Are there smokers in your home?	YES	NO	UNSURE
Do you have safety concerns for your home?	YES	NO	UNSURE
If so, what are your concerns?			
Does your baby drink: **Breast Milk Formula Unsure**			
If you are giving formula, how many ounces does your child take in 24 hours? _____ oz. Type of formula?			
Who provides daytime care for your child?			

Over the past two weeks has mom been feeling sad, anxious, hopeless or depressed?	YES	NO	UNSURE
Over the past two weeks, has mom felt very little or no interest or pleasure doing things?	YES	NO	UNSURE
Is your child on any medications or supplements including vitamins? If so, please list below:			

Do you have any other concerns about your child's development or any other concerns you would like to discuss with the provider? If YES, please describe below: