Well Child Check:
Newborn/2 Week Visit

marinhealth Medical Network | UCSF Health

Child's Name: _____ DOB: _____ Date: _____

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

Does your child lift his/her head?	YES	NO	UNSURE
Does your child move arms equally and legs equally?	YES	NO	UNSURE
Does your child seem to look at faces, objects or light?	YES	NO	UNSURE
Does your child follow objects with his/her eyes?	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
Does your baby drink: **Breast Milk Formula Both**			
If you are giving formula, how many ounces does your child take in 24 hours? _____ oz. Type of formula?			
About how many wet diapers has your baby had in the last 24 hours? _____			
How many times has your baby pooped in the last 24 hours? _____ What color? _____			
Are you interested in seeing a lactation specialist?	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?			
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: