

2 MONTH WELL CHECK-UP

NAME _____ DATE _____ DOB _____

Caregiver concerns: _____

Daily Activities

Sleep (nearly 16-20 hrs./day) _____
Awakes during night? _____
How many times? _____
Activities when awake? _____

Feeding

Formula/breast: how often? _____
How many times/day (nl:5-6x/day)? _____
How many ounces per feed? _____
Per day? _____
Other foods (may add cereal, beginning with rice cereal)
How often? (nl:2x/day) _____

Stools

Number _____
Color _____
Consistency _____
Constipation _____

Development

Smiles _____
Lifts head _____
Follows with eyes past midline _____

Physical Exam

Please use growth chart

Hgt _____ % _____
Wgt _____ % _____
H.C. _____ % _____

HEENT _____

Neck _____

GU _____

Lungs _____

Ortho _____

Heart _____

Neuro _____

Abdomen _____

Skin _____

Impression

Plan DTaP & OPV#1 / IPV#1

Topics Discussed

- | | |
|--|---|
| 1. <i>Safety & Prevention</i>
Don't leave child alone on table/bed _____
Obesity prevention. Don't overfeed _____ | 3. Appropriate dose of Tylenol or Advil for temperature > than 101 degrees that is related to DTaP immunization _____ |
| 2. <i>Interaction</i>
Use of mirrors and bright colors _____
Speak to baby _____
Handout _____ | 4. Parental smoking _____
5. Bulb Syringe _____
6. Other _____ |

Return to office _____