

2 WEEK WELL CHECK-UP

NAME _____ DATE _____ DOB _____

Caregiver concerns: _____

Daily Activities

Awakes during night? Yes [] No []
How many times? _____
Naps during day? _____
How long each nap? _____
How many times? _____

Feeding

Formula or breast milk? _____
How often? _____
How many ounces per feed? _____
Per day? _____
Colic? _____
Regurgitation? _____

Stools

Number _____
Color _____
Consistency _____
Constipation _____

Development

Stares at objects: _____
Smiles: _____
Alert to sound: _____
Raises head from prone: _____

Physical Exam

Please use growth chart

Hgt _____ % _____

Wgt _____ % _____

H.C. _____ % _____

HEENT _____

Neck _____

GU _____

Lungs _____

Ortho _____

Heart _____

Neuro _____

Abdomen _____

Skin _____

Impression

Plan

Topics Discussed

1. Skin Care _____
2. Amount of clothing _____
3. Washing bottles _____
4. Car seat & appropriate position _____
5. Parental smoking _____
6. Sibling's response _____
7. Warming milk _____
8. Parent-child interaction _____
9. Talking to baby _____
10. How mother handles crying _____
11. Back to sleep _____
12. Mobiles _____
13. Other _____

Return to office _____