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_____
Lungs_____
Heart_____
Abdomen_____

GU_____
Ortho_____
Neuro_____
Skin_____

Impression
_____
_____

Plan DTaP & OPV#1 / IPV#1
_____
_____

Topics Discussed
1. ***Safety & Prevention***
   Don't leave child alone on table/bed_____
   Obesity prevention. Don't overfeed_____
2. ***Interaction***
   Use of mirrors and bright colors_____
   Speak to baby_____
   Handout_____
3. Appropriate dose of Tylenol or Advil for temperature > than 101 degrees that is related to DTaP immunization_____
4. Parental smoking_____
5. Bulb Syringe_____
6. Other_____

Return to office_____