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_____
Lungs_____
Heart_____
Abdomen_____

GU_____
Ortho_____
Neuro_____
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_____