

2 Month Visit Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Birthdate:** _____ **Today's Date:** _____

General:

	CIRCLE	*(If yes, explain below)
Do you have any specific concerns for today's visit?	No	Yes*
Is your infant taking any prescription medications?	No	Yes*
Are your infant's vaccines covered by your insurance plan?	No	Yes
Is your infant seeing a specialist for any ongoing medical problem(s)?	No	Yes*
Has your infant been seen in a hospital ER or treatment center since the last visit here?	No	Yes*
Does your child have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes*

Family Medical:

Do the parents have any significant medical issues that we should be aware of?	No	Yes*
Have there been any other significant family medical issues recently?	No	Yes*

Social:

Are the biological parents married?	No	Yes
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*

Symptom Review:

Has the infant had any fever (over 100.4), runny nose or significant cough in the <u>last 3 days</u> ?	No	Yes*
Is the infant overly irritable?	No	Yes*
Does the infant wake for feedings regularly?	No	Yes*
Is there any eye redness or discharge?	No	Yes*
Did your infant FAIL the infant hearing screen?	No	Yes*
Is the infant having any significant breathing problems that you are concerned about?	No	Yes*
Does your infant have any forceful, projectile vomiting?	No	Yes*
Do you have any concerns regarding your infant's stooling habits?	No	Yes*
Do you have any concerns regarding your infant's voiding/urinary habits?	No	Yes*
Does your infant have a weakness or failure to use any of his/her arms or legs?	No	Yes*
Does your infant prefer to keep his head to one side most of the time?	No	Yes*
Does your infant have any unusual rashes that you are concerned about?	No	Yes*

*Explain 'YES' Answers: _____