

MUNDELEIN PEDIATRICS

2 Month Well Exam

Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

- 1. Breastfeeding: Yes/No Concerns: _____
- 2. Formula feeding: Yes/No Concerns: _____
- 3. Awakens at night to feed: Yes/No Concerns: _____
- 4. Excessive spitting or vomiting: Yes/No Concerns: _____
- 5. Urinating well: Yes/No Concerns: _____
- 6. Normal bowel movements: Yes/No Concerns: _____
- 7. Sleeps on back: Yes/No Concerns: _____
- 8. Rides in a rear-facing car seat in the back seat: Yes/No
- 9. Takes vitamins: Yes/No Product name: _____
- 10. Emergency room visits: Yes/No _____
- 11. Illness since last visit: _____
- 12. Developmentally: smiles responsively, coos/vocalizes, startles to loud noises, likes tummy time, holds head up while on belly, follows you with his/hers eyes

Please circle the answer that most appropriately describes your home environment:

- 1. Smoke-free home and car: Yes/No
- 2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
- 3. Daycare: None/Relative/Center/Babysitter
- 4. Primary care taker: Mom/Dad/Grandparents
- 5. Household composition:
Adult(Names/Ages): _____
Children(Names/Ages): _____
- 6. New health problems in parents or siblings: _____
- 7. Past vaccine reactions: Yes/No
- 8. Sibling rivalry: Yes/No
- 9. Post-partum depression in mom (crying a lot, sad, depressed): Yes/No

Do you have any other concerns you wish to discuss? Yes/No

