# Pediatric Health Maintenance: 2 or 4 Weeks
## Parent Questionnaire

Virginia Mason

| Patient Information | |
|---|---|
| First & Last Name: | |
| Preferred Name: | |
| Date of Birth: | |

| General Health ☐ I'd like to discuss | | |
|---|---|---|
| ☐ Yes | ☐ No | Will you be returning to work and/or will your child attend daycare? |

| Feeding and Sleeping ☐ I'd like to discuss | | |
|---|---|---|
| What is your baby fed? ☐ Breastmilk ☐ Formula (type): | | |
| Ounces per feeding (if bottle fed): | | |
| My baby feeds every _____ hours during daytime and is usually up _____ times during the night to feed. | | |
| Where does your baby sleep? ☐ Crib/bassinet ☐ Parent's bed ☐ Other | | |
| ☐ Yes | ☐ No | Do you think your baby's bowel movements are normal? |

| Development ☐ I'd like to discuss | | |
|---|---|---|
| ☐ Yes | ☐ No | Can your baby lift his or her head slightly when lying face down? |
| ☐ Yes | ☐ No | Does your baby move his or her arms and legs equally? |
| ☐ Yes | ☐ No | Can you calm your baby? |
| ☐ Yes | ☐ No | Does your baby look at you briefly? |
| ☐ Yes | ☐ No | Does your baby respond to noise? |

| Safety ☐ I'd like to discuss | | |
|---|---|---|
| ☐ Yes | ☐ No | Does your home have functioning smoke detectors? |
| ☐ Yes | ☐ No | Is your water heater turned down to below 120 degrees? ☐ Don't Know |
| ☐ Yes | ☐ No | Does your child ride in a rear-facing car seat, in the back seat? |
| ☐ Yes | ☐ No | Do you leave your baby alone on the changing table, sofa, or bed? |
| ☐ Yes | ☐ No | Are there any smokers in your home? |
| ☐ Yes | ☐ No | Are you afraid of your partner or anyone close to you? |
| ☐ Yes | ☐ No | Do you feel overly stressed or unsupported? |

| Specific Concerns/ Questions for Visit |
|---|
| |

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 2-4 Weeks form.

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME & ID #