PEDIATRIC HEALTH MAINTENANCE – 2 or 4 Weeks
Parent Questionnaire

General

Do you have questions or concerns you would like to discuss today? ______ No ______ Yes

If yes, please specify: ____________________

Will your child be in daycare or in the care of another person outside of parents? ______ No ______ Yes

Feeding and Sleeping

What is your baby fed? ☐ Breastmilk ☐ Formula (brand/type) ____________________

Ounces per feeding (if bottle fed): ____________________

My baby feeds every ________ hours daytime and is usually up ________ times during the night to feed.

Are you giving your baby any vitamins? ☐ No ☐ Vitamin D ☐ Iron

Where does your baby sleep? ☐ Crib/bassinet ☐ Parent's bed ☐ Other ____________

Does your baby sleep on their back? ______ Yes ______ No

Do you think your baby's bowel movements are normal? ______ Yes ______ No

Development

Can your baby lift their 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? ______ Yes ______ No

Safety

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? ______ Yes ______ No

Does your child ever ride in the front seat of a vehicle? ______ No ______ Yes

Do you leave your baby alone on the changing table, sofa, or bed? ______ No ______ Yes

Are there smokers in your home? ______ No ______ Yes

Do you have a firearm in your home? ______ No ______ Yes

If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them? ______ Yes ______ No

Are you afraid of your partner or anyone close to you? ______ No ______ Yes

Do you feel overly stressed or unsupported? ______ No ______ Yes

____________________ ____________________

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

PATIENT NAME

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