KAISER PERMANENTE®

# Well-Visit Questionnaire
## Children Age 2 Months

**Your baby is 2 months old!**

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your baby for their well visit. At this visit, we will cover many important topics to support your baby's growth, development, wellness, and safety, and we'll give your baby any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your baby.

| **Do you have specific concerns? Check all that apply, then briefly describe your concern:** | |
|---|---|
| ☐ Well Visit ☐ Belly button ☐ Breathing ☐ Constipation ☐ Cough ☐ Development ☐ Diaper rash<br>☐ Eye discharge ☐ Feeding ☐ Fever ☐ Fussiness/crying ☐ Genitals ☐ Growth/nutrition<br>☐ Head shape ☐ Nasal congestion ☐ Rash ☐ Stool change ☐ Vaccines ☐ Vomiting<br>☐ Other (please explain):_____<br>Briefly describe your concern:_____ | |
| **Health Changes** | |
| Has your baby received any specialty or emergency care since the last visit?<br>If Yes, please describe: _____ | ☐ Yes ☐ No |
| Has your baby or anyone in the family developed a new health condition or died?<br>Include parents, brothers, sisters, grandparents, aunts, uncles or cousins.<br>If Yes, please describe: _____ | ☐ Yes ☐ No |
| **Nutrition, Feeding and Supplements – Tell us about what your baby eats.** | |
| My baby is (check all that apply):<br>☐ Breastfeeding ☐ Drinking pumped breast milk ☐ Drinking formula<br>☐ Other: eating/drinking anything else (please describe): _____ | |
| My baby receives daily Vitamin D: | ☐ Yes ☐ No |
| Please list any other vitamins, supplements, or over-the-counter medicines you give your baby:<br>_____ | |
| **Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.** | |
| **My baby:** | |
| Seems happy to see me: | ☐ Yes ☐ No |
| Smiles when I smile: | ☐ Yes ☐ No |
| Lifts their head when lying on their stomach: | ☐ Yes ☐ No |
| Opens and shuts their hands: | ☐ Yes ☐ No |
| Brings their hands together briefly in the middle of their body: | ☐ Yes ☐ No |
| **Vision and Hearing** | |
| My baby's eyes mostly track together and only sometimes cross: | ☐ Yes ☐ No |
| My baby follows an object or me with their eyes as it moves around: | ☐ Yes ☐ No |
| My baby turns toward sounds: | ☐ Yes ☐ No |

KAISER PERMANENTE®

# Well-Visit Questionnaire

## Children Age 2 Months

| | |
|---|---|
| **Safety** | |
| My baby rides in a rear-facing car seat in the back seat of the car for every car ride: | ☐ Yes ☐ No |
| **Sleep** | |
| **My baby:** | |
| Sleeps in a (choose all that apply):<br>☐ Crib or bassinet ☐ Shared bed ☐ Other product - please describe: _____ | |
| Is always put to sleep on their back: | ☐ Yes ☐ No |
| **Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.** | |
| Do you have concerns for low mood, depression, or anxiety in yourself or your partner? | ☐ Yes ☐ No |
| What is your plan for childcare?<br>☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center | |
| Do you need assistance finding affordable and safe childcare? | ☐ Yes ☐ No |
| **Is there anyone who lives in your home or cares for your child who:** | |
| - Smokes or vapes tobacco or marijuana: | ☐ Yes ☐ No |
| - Uses prescription pain medication: | ☐ Yes ☐ No |
| - Uses other drugs: | ☐ Yes ☐ No |
| - Consumes alcohol more than an occasional drink (a beer or glass of wine at night): | ☐ Yes ☐ No |
| **Within the past 12 months, have you:** | |
| - Run out of food or been worried your food would run out before there was money to buy more? | ☐ Yes ☐ No |
| - Worried about housing or had to move? | ☐ Yes ☐ No |
| - Had difficulty getting other supplies and services you need to care for your baby?<br>Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation. | ☐ Yes ☐ No |

NOT TO BE FILED IN THE MEDICAL RECORD



Rev. Date 2021013