ABC Pediatrics

Two Month Pre-visit Questionnaire

Patient Name_____ Date_____

Bathes: (every other day) (daily)

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Formula: _____ Ounces per feeding? _____Every how many hours? _____

# of stools Daily_____ # of voids Daily_____ # of hours sleeping at ONE time_____

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things?_____

Have there been any major changes in your family recently other than your baby's birth?

_____

Developmental Milestones (circle all that apply)

□ Bears weight on arms	□ Different Cries for different needs	□ Follows objects past midline	□ Responds to sound
□ Says Ohh/Ahh	□ Squeals	□ Turns to voice	□ Lifts head
□ Smiles Spontaneously	□ Moves Symmetrically	□ Laughs	
□ Regards Face	□ Follows objects 180 degress	□ Fixates visually on moving objects	

Any other questions or concerns you would like to discuss?

TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was you child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**

Weight_____ Temp_____Height_____ Head Circumference_____