



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)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Bears weight on arms | <input type="checkbox"/> Different Cries for different needs | <input type="checkbox"/> Follows objects past midline | <input type="checkbox"/> Responds to sound |
| <input type="checkbox"/> Says Ohh/Ahh | <input type="checkbox"/> Squeals | <input type="checkbox"/> Turns to voice | <input type="checkbox"/> Lifts head |
| <input type="checkbox"/> Smiles Spontaneously | <input type="checkbox"/> Moves Symmetrically | <input type="checkbox"/> Laughs | |
| <input type="checkbox"/> Regards Face | <input type="checkbox"/> Follow objects 180 degrees | <input type="checkbox"/> Fixates visually on moving objects | |

Any other questions or concerns you would like to discuss?

Weight _____ Temp _____ Height _____ Head Circumference _____