2 MONTHS

Health Maintenance Questionnaire

LPG LINCOLN PEDIATRIC GROUP

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

PARENTS' CONCERNS

List concerns you have? 1.
2.
3.
4.
5.

Please check any body areas that concern you:

☐Head	☐Heart	☐Bones	☐Hormones
☐Eyes	☐Lungs	☐Joints	☐Blood
☐Ears	☐Intestines	☐Muscles	☐ Glands
☐Nose	☐Kidneys	☐Brain	☐Immunity
☐Mouth	☐Genitals	☐Nerves	
☐Throat	☐Skin	☐Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION

HISTORY

Describe any recent injuries or illnesses:

List medications taken routinely: ☐none

Note any new stresses in the family:

Are siblings adjusting to baby OK? ☐No siblings ☐Yes ☐No

Will Mom return to work/school? ☐No ☐at _____ wks old ☐is back to work/school

Will baby go to day care? ☐No ☐Yes ☐Nanny ☐In day care now.

How many kids in the room/home? _____

Are there smokers in your baby's home or day care? ☐No ☐outside ☐other room

- Call with rectal temp >100.4^{O}
- Avoid 2nd hand smoke.

NUTRITION

FORMULA FEEDING:

How many ounces in 24 hrs? _____ What formula? _____

BREAST FEEDING:

How many months do you plan to breastfeed? _____

Mom's medications: ☐prenatal vitamin Other:

IN THE PAST 24 HOURS:

Is baby nursed on demand? ☐yes ☐no

Latched _____ times Average minutes each time:_____

Pumped ____ times Total ounces: _____

Fed _____ ounces of pumped milk Fed _____ ounces of formula– type:_____

BREAST FEEDING RECOMMENDATIONS

- 8-12 feedings in 24hrs is typical.
- Nurse at least every 3 hours during the day so baby will sleep longer at night.
- Don't go more than 5hrs at night without removing milk (pump if baby sleeps longer).
- If baby is supplemented with pumped breast milk or formula → pump (supply : demand)
- Expect at least 1 feeding at night.
- Should gain about 6oz per week and follow the growth curve at check-ups.
- Request a weight check if baby is excessively sleepy, fussy, or not clearly gaining weight.
- Needs at least 24oz of milk each day.
- Spitting up does not always indicate over feeding, but rather an immature and "loose" valve between esophagus and stomach.
- Don't restrict feedings / Feed on demand.
- Don't overuse the pacifier. Is baby hungry?
- Back to work? Pump/freeze milk properly.
- Introduce bottle if returning to work.
- Delay solids until 6 months old.
- Mom should not diet. Drink to thirst.
- Vitamins as prescribed by the doctor.

How many of each per day: spit ups: _____ wets: _____

How often does baby pass stool? _____

STOOLING EXPECTATIONS

BREAST FED: Stools several times per day or only once per week. This is normal if it's soft.

FORMULA FED: Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM

Ht_____ Wt_____ HC_____ VS:_____

EXAM:

Lab/Immunizations

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Name: Birth Date:

2 month

DEVELOPMENT AND BEHAVIOR

☐Yes ☐No Are you concerned about your child's development or behavior?

Y N
☐☐Does baby respond to sounds by becoming alert and quiet?
☐☐**Does s/he look at your face and follow you with his/her eyes past midline?**

MOTOR
Y N
☐☐Does baby hold his/her head in the midline when held in an upright position?
☐☐Does baby lift his/her chest off the floor during "tummy time?"
☐☐Will baby grasp a finger or rattle placed in his/her hand?

LANGUAGE
Y N
☐☐Do you talk, read and sing to baby?
☐☐Does s/he respond to your voice by cooing?

SOCIAL
Y N
☐☐Does s/he enjoy looking at a mobile and non-breakable mirror?
☐☐Does baby respond by smiling?
☐☐Can s/he be consoled from crying most of the time?
(Colic usually goes away around 3 months of age.)

SLEEP How many hours does baby sleep at a time?
Y N
☐☐Have you established a bedtime routine?
☐☐Do you put baby down on his/her back?
☐☐Do you avoid bulky bedding in the crib?
☐☐Do you alternate baby's head position to prevent flattening of the skull?
☐☐Do you try to avoid falling asleep with baby in your bed or while resting on a couch or soft chair?

Where does baby sleep?

SAFETY AWARENESS

The shaded items are new for the 2 month visit.

Y N
☐☐Do you avoid drinking hot liquids while holding your baby?
☐☐Do you limit sun exposure?
☐☐Do you avoid putting baby in the car seat / bouncy seat set in high places?
☐☐Do you avoid the use of baby walkers?
☐☐Is baby's car seat rear facing in the back seat? →
☐☐Is the water temperature in your house less than 120 degrees?
☐☐Do you have a fire escape plan?
☐☐Do you check your smoke detectors regularly?
☐☐Do you monitor baby closely around young siblings or pets?
☐☐Do you avoid putting necklaces or pacifiers on strings around baby's neck?
☐☐Are you aware that shaking your baby could cause permanent brain damage?

2019 Nebraska Car Seat Law:
Kids ride rear-facing until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer.
Kids under 8 must ride in the back seat.

POSTPARTUM DEPRESSION SCREENING

☐**Yes** ☐**No** **Are you concerned about your mood or feeling depressed?**

In the past 7 days:

1. I've been able to laugh and see the funny side of things.
   0 As much as I used to.
   1 Not quite so much now.
   2 Definitely not so much now.
   3 Not at all.

2. I've looked forward with enjoyment to things.
   0 As much as I ever did.
   1 Rather less than I used to.
   2 Definitely less than I used to.
   3 Hardly at all.

3. I've blamed myself unnecessarily when things went wrong.
   3 Yes, most of the time.
   2 Yes, some of the time.
   1 Not very often.
   0 No, never.

4. I've been anxious or worried for no good reason.
   0 No, not at all.
   1 Hardly ever.
   2 Yes, sometimes.
   3 Yes, very often.

5. I've felt scared or panicky for no very good reason.
   3 Yes, quite a lot.
   2 Yes, sometimes
   1 No, Not much.
   0 No, Not at all.

6. Things have been getting on top of me.
   3 Yes, most of the time I haven't been able to cope at all.
   2 Yes, sometimes I haven't been coping as well as usual.
   1 No, most of the time I have coped quite well.
   0 No, I've been coping as well as ever.

7. I've been so unhappy that I've had difficulty sleeping.
   3 Yes, most of the time.
   2 Yes, sometimes.
   1 Not very often.
   0 No, not at all.

8. I've felt sad or miserable.
   3 Yes, most of the time.
   2 Yes, quite often.
   1 Not very often.
   0 No, not at all.

9. I've been so unhappy that I've been crying.
   3 Yes, most of the time.
   2 Yes, quite often.
   1 Only occasionally.
   0 No, never.

10. The thought of harming myself has occurred to me.
   3 Yes, quite often.
   2 Sometimes.
   1 Hardly ever.
   0 Never.

I have a mental health therapist: Yes No
I am currently taking medication for anxiety / depression / mental health. No Yes: drug name:

Who answered the above questions?

Thank you for helping us help you and your child!!