



Health Maintenance Questionnaire

2 WEEK

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:

- | | | | |
|---------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Heart | <input type="checkbox"/> Bones | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestines | <input type="checkbox"/> Muscles | <input type="checkbox"/> Glands |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Brain | <input type="checkbox"/> Immunity |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Genitals | <input type="checkbox"/> Nerves | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> 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: _____

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

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: _____

Pain with latching is none mild moderate severe

Was baby still fussy / hungry after nursing? no sometimes always

Did you have to wake baby for feedings? no sometimes always

Pumped _____ times Total ounces: _____

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

- Call with rectal temp >100.4°
- Saline nose drops / nasal suctioning.

- Avoid 2nd hand smoke.

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)
- Should gain at least 7oz per week or 1oz per day.
- 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 the esophagus and stomach.
- Don't restrict feedings / Feed on demand
- Don't overuse the pacifier. Is baby hungry?
- Consider pumping each morning after nursing to freeze milk for return to work.
- Introduce a recommended bottle if desired.
- Mom should not diet. Drink to thirst.
- Vitamins as prescribed by the doctor.

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

STOOLING EXPECTATIONS

BREAST FED: Expect 6-8 wets and 3-4 loose mustard curdy stools per day.
Frequency may decrease.

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

PHYSICAL EXAM		Lab/Immunizations
Ht _____	Wt _____	VS: _____
EXAM:	HC _____	
ASSESSMENT		PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name:

Birth Date:

2 weeks

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's development or behavior?	
Y N	
<input type="checkbox"/> <input type="checkbox"/> Does baby respond to sound by blinking, crying, quieting or startling? <input type="checkbox"/> <input type="checkbox"/> Does s/he move arms and legs equally? <input type="checkbox"/> <input type="checkbox"/> Does baby lift his/her head slightly during "tummy time?" <input type="checkbox"/> <input type="checkbox"/> Can s/he be consoled from crying most of the time? (Colic may set in at this time. Crying 2-3 hrs/day is normal.)	
S L E E P	How many hours does baby sleep at a time? (3-4 hrs is typical)
	Y N
<input type="checkbox"/> <input type="checkbox"/> Does your baby sometimes breathe irregularly, ie fast and then pause? (This is normal and will resolve soon. It is called " <i>periodic breathing</i> " and is of no concern, as long as there are no blue or pale limp spells.) <input type="checkbox"/> <input type="checkbox"/> Do you put him/her down on his/her back? <input type="checkbox"/> <input type="checkbox"/> Do you avoid stuffed animals, bumpers and blankets in the crib? <input type="checkbox"/> <input type="checkbox"/> Do you alternate baby's head position to prevent flattening of the skull? <input type="checkbox"/> <input type="checkbox"/> 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?	

POSTPARTUM DEPRESSION SCREENING	
<input type="checkbox"/> Yes <input type="checkbox"/> 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.	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.
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.	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.
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.	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.
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.	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.
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.	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!!