

# Jessica Davis MD

The New Mom's Family Doctor  
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NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

## TWO MONTH WELL CHILD VISIT

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES		DISCUSSION TOPICS	
Yes	No	Overall, I feel confident that my child is doing well	General questions
Yes	No	I have enough help with the baby	Family Support
No	Yes	There have been recent changes or stresses in our family	Exhaustion
		Who lives with you and the baby? _____	Sibling, Partner Adjustment
No	Yes	Parenting is harder than I thought it would be.	Parenting Support
No	Yes	I am having some "baby blues"	Postpartum Depression
No	Yes	My baby is fussier than the average baby.	Infant temperament/colic
No	Yes	I plan to return to work/school. When?	Childcare arrangements
FEEDING/SLEEPING		*****	
No	Yes	I have questions about my baby's feeding	Continue breastfeeding
		My baby takes breast milk every ___ hrs, or _____	No solids until 6 months
		formula, ___ oz every ___ hrs	Avoid bottle propping/in bed
No	Yes	My baby has a problem with spitting up	normal vs pathologic reflux
Yes	No	I am satisfied with my child's sleep schedule. # naps per day _____ #hrs sleep at night	Vit D supp if <500cc formula
		Longest sleep period: Daytime _____ Nighttime _____	Normal range 2-8 hrs
		How do you get your baby to sleep?	
		<b>Feeding / Rocking / Pacifier / Self / Other</b>	
		Where does your baby sleep? _____	Safe sleep environment
VOIDING / STOOLING		*****	
Yes	No	My baby poops and pees normally	Normal variations
		Wet diapers _____ Stool diapers _____ (per day)	
BEHAVIOR / DEVELOPMENT		*****	
No	Yes	I have questions about my child's development	R-PDQ if concerns
Yes	No	My baby looks at my face.	Separation anxiety
Yes	No	My baby smiles at people	Anticipate rolling / falls
Yes	No	My baby makes cooing noises	Tummy time
Yes	No	My baby can lift his/her head when lying on his/her tummy	
Yes	No	My baby responds to noises	
PREVENTION		*****	
No	Yes	My baby lives with someone who smokes cigarettes	Risk of tobacco exposure
No	Yes	My child or another person living with us was born outside the U.S. or has	Assess TB risk
-	-	traveled to Asia, Mexico, Latin America, or Africa	Car seat rear facing until 2
No	Yes	I have a family member who has had Tuberculosis	no exceptions with carseat
Yes	No	I always keep my child in a car seat and in the back seat	SIDS prevention
Yes	No	My baby sleeps only on his/her side or back	Crib safety
Yes	No	I have smoke alarms and test them regularly	
Yes	No	My hot water heater is set to 120°F	Burn prevention
No	Yes	I have concerns that my baby is not safe at home or daycare	Water safety
Yes	No	I know how to take a temperature and treat a minor cold	Call for fever over 100.4
No	Yes	I have questions about immunizations/shots	Injuries #1 cause of death
No	Yes	Is there anything else you want to discuss today?	Poison control 800-222-1222