Sutter Health
With You. For Life.

Your Child's Name: _____

2 Month Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you.

Can your child hold the head somewhat steady as you pick him/her up?	Yes	No	Unsure
Does your child hold an object briefly?	Yes	No	Unsure
Does your child follow you or objects with her/his eyes?	Yes	No	Unsure
Does your child look at objects?	Yes	No	Unsure
Does your child look at faces?	Yes	No	Unsure
Does your child smile?	Yes	No	Unsure
Does your child coo (make "ooh", "aah" sounds)?	Yes	No	Unsure

Does your baby drink breastmilk or formula? Breastmilk Formula Both

If you are giving formula how many ounces does your child take in 24 hours? _____oz

Type of formula?_____

Do you always place your infant to sleep on the back?	Yes	No	Unsure
Does the baby always sleep in a crib or bassinette?	Yes	No	Unsure
Do you have working smoke alarms in your home?	Yes	No	Unsure
Are there smokers in your home?	Yes	No	Unsure
Do you have any safety concerns in your home?	Yes	No	Unsure

If so, what are your concerns?_____

Over the past 2 weeks, has mom ever felt down, depressed, or hopeless?	Yes	No	Unsure
Over the past 2 weeks, has mom felt little interest or pleasure in doing things?	Yes	No	Unsure

Who provides daytime care for your child? _____

Is your child on any medications or supplements, including vitamins? If so, please list below:

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?