

Newborn/2 Week Visit:

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

Does your child lift her head? Yes No Unsure

Does your child move arms equally and legs equally? Yes No Unsure

Does your child seem to look at objects or lights? Yes No Unsure

Does your child seem to look at faces? 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? _____

Are you interested in seeing a lactation specialist? Yes No Unsure

Is there a family history of hay fever, asthma, eczema or food allergies? Yes No Unsure
If yes, please explain:

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

Is your child on any medications or supplements? 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?