



PATIENT NAME: _____

Questions for 2 Month Visit

DATE: ____ / ____ / ____

Please complete the following questions as they apply to your infant.

NUTRITION

Breastfeeding

Are you breast feeding? yes no

Do you feel that breast feeding is going well? yes no

If no, please explain: _____

Regarding breast feeding, are you?

exclusively breast feeding exclusively pumping breast feeding and pumping breast feeding and supplementing with formula

Does your infant feed from one or both sides? one side both sides

Approximately how long does your infant feed from each breast?

< 15 minutes 15 to 30 minutes 30 to 45 minutes > 45 minutes

Approximately how often does your infant feed?

every 1 to 2 hours every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

5 to 6 7 to 8 9 to 10 10 to 12 > 12

Have you introduced an occasional bottle? yes no

Do you currently plan on returning to work while breast feeding or pumping? yes no

Are you interested in information regarding breast feeding or pumping at work? yes no

Are you currently taking your prenatal vitamins? yes no

Formula

Regarding formula, is your infant?

completely formula fed supplemented with formula after breast feeding not formula fed

How many ounces does your infant take per feeding?

1 to 2 oz 2 to 4 oz 4 to 6 oz 6 to 8 oz

Approximately how often does your infant feed?

receives formula as a supplement after each breast feeding receives formula randomly as a supplement to breast feeding
 every 1 to 2 hours every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

5 to 6 7 to 8 9 to 10 10 to 12 > 12

Approximately how long does it take to feed your infant?

< 15 minutes 15 to 30 minutes 30 to 45 minutes > 45 minutes

What type of formula do you feed your infant?

Enfamil Lipil Similac Advance Nestle Goodstart Isomil Prosobee Nutramigen
 Enfacare Neosure Other: _____



ELIMINATION

How many wet diapers does your infant have per day?

- > 6 < 6

How frequent does your infant have a bowel movement?

- > 6 per day 3 to 6 per day 1 to 2 per day 1 per day
 every other day every 3 to 4 days > every 4 days

Is your infant having any problems with his/her bowel movements? yes no

If yes, please explain: _____

SLEEP

How long does your infant sleep (consecutively) at night?

- 1 to 2 hours 2 to 3 hours 3 to 4 hours 4 to 6 hours > 6 hours

Is your infant sleeping on his/her back? yes no

Is your infant co-sleeping with you? yes no

Is your infant using a pacifier to fall asleep? yes no

VISION

Do you have any concerns regarding your infant's vision? yes no

If yes, please explain: _____

HEARING

Do you have any concerns regarding your infant's hearing? yes no

If yes, please explain: _____

DEVELOPMENT

- | | | |
|--|------------------------------|-----------------------------|
| Coos and vocalizes in response to being talked to | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Is attentive to voices | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Follows you with his/her eyes | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Smiles responsively to your smile | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Shows pleasure in interaction with adults, especially parents and other primary caregivers | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| When lying on stomach, lifts head, neck, and upper chest with support on forearms | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| When help upright, has some head control | <input type="checkbox"/> yes | <input type="checkbox"/> no |

SAFETY

What type of car seat does your infant use?

- a 5 point (rear facing) infant carrier in the back seat of the vehicle other: _____

J.A.N. 27.2010 Signature of Provider _____ Date: ____ / ____ / ____