KAISER PERMANENTE®

Two Months • Well Child Visit

Name: _____

Please answer the following questions and hand this form to the clinical assistant. Your answers will help your doctor choose the best topics to discuss with you during your visit today. Skip any questions that you don't understand or that do not apply. This information is confidential.

What would you like to discuss with your doctor today?

1.	Since your last visit, have there been any MAJOR illnesses, hospitalizations, changes or stresses for your family or baby?	❒ Yes	❒ No
2.	Have you been feeling sad or depressed since the birth of your baby?	❒ Yes	❒ No
3.	Is your baby taking a vitamin supplement?	❒ No	❒ Yes
4.	If bottle feeding, do you always feed your baby in the upright position?	❒ No	❒ Yes
5.	Do you ever prop your baby's bottle to feed him or her?	❒ Yes	❒ No
6.	Do you have any concerns with your baby's bowel movements?	❒ Yes	❒ No
7.	When your baby boy urinates (pees), can he shoot it straight out?	❒ No	❒ Yes
8.	Does your baby cry continuously for more than two hours a day?	❒ Yes	❒ No
9.	Do you cuddle and talk to your baby every day?	❒ No	❒ Yes

SAFETY

10.	Do you always place your baby on his or her back to sleep?	❒ No	❒ Yes
11.	Does your baby usually sleep in bed with you?	❒ Yes	❒ No
12.	Do you ever leave your baby alone on the bed or changing table?	❒ Yes	❒ No
13.	Do you ever drink hot liquids while holding the baby?	❒ Yes	❒ No
14.	Do you place your baby in a car seat facing backwards, in the back seat?	❒ No	❒ Yes
15.	If you carry your baby in an infant seat or carrier, do you always put the seat on the ground and fasten the belt (so your baby won't fall out)?	❒ No	❒ Yes
16.	Do you know that shaking your baby when angry or frustrated can be very dangerous?	❒ No	❒ Yes
17.	Do you use a hat or umbrella to protect your baby from the sun if he or she is outside for more than 10 minutes?	❒ No	❒ Yes

DEVELOPMENT

18.	Does your baby smile at you?	❒ No	❒ Yes
19.	Does your baby coo?	❒ No	❒ Yes
20.	Does your baby follow your face with his or her eyes?	❒ No	❒ Yes
21.	Can your baby lift his or her head when lying on the stomach?	❒ No	❒ Yes
22.	Does your baby respond to loud noises?	❒ No	❒ Yes

Please turn over.

Directions

- If you have *not* completed the following questionnaire for Kaiser Permanente on behalf of your child, please complete the survey below.
- If you have completed this survey on behalf of your child during a previous visit, you do not need to fill this out again.

Lead Screening

1.	Does your child have a sibling or playmate who has or had lead poisoning?	❒ Yes	❒ No
2.	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently (within the past 6 months) been renovated or remodeled?	❒ Yes	❒ No
3.	Does your child live in or regularly visit a house or child care facility built before 1950?	❒ Yes	❒ No

Tuberculosis Screening

1.	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	❒ Yes	❒ No
2.	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	❒ Yes	❒ No
3.	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	❒ Yes	❒ No
4.	Is your child infected with HIV or exposed to someone who is infected with HIV?	❒ Yes	❒ No