To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. Maternal Depression screening is also part of this visit. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today?  ○ No  ○ Yes, describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs?  ○ No  ○ Yes, describe:

Have there been major changes lately in your baby’s or family’s life?  ○ No  ○ Yes, describe:

Have any of your baby’s relatives developed new medical problems since your last visit?  ○ No  ○ Yes  ○ Unsure  If yes or unsure, please describe:

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  ○ No  ○ Yes  ○ Unsure

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby’s development, learning, or behavior?  ○ No  ○ Yes, describe:

Check off each of the tasks that your baby is able to do.

☐ Smile back at you.
☐ Make sounds that let you know he is happy or upset.
☐ Make short cooing sounds.
☐ Move both arms and legs together.
☐ Hold her chin up when she is on her stomach.
☐ Open and shut his hands.
**2 MONTH VISIT**

**RISK ASSESSMENT**

<table>
<thead>
<tr>
<th>Vision</th>
<th>☐ No</th>
<th>☐ Yes</th>
<th>☐ Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have concerns about how your baby sees?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANTICIPATORY GUIDANCE**

*How are things going for you, your baby, and your family?*

**YOUR FAMILY’S HEALTH AND WELL-BEING**

<table>
<thead>
<tr>
<th>Living Situation and Food Security</th>
<th>☐ No</th>
<th>☐ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is permanent housing a worry for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Does your home have enough heat, hot water, and electricity?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Do you have health insurance for yourself?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Within the past 12 months, did the food you bought not last, and you did not have money to get more?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Support</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you getting enough rest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been out of the house without your baby (such as to the store, to restaurants, or on a walk)?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Have you found someone to care for your baby when you return to work or school?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>If yes, are you comfortable with these arrangements?</td>
<td>☐ NA</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

**HOW YOU ARE FEELING**

<table>
<thead>
<tr>
<th></th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had your 6-week after-birth checkup?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have other children, are you able to spend time with them?</td>
<td>☐ NA</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

**CARING FOR YOUR BABY**

<table>
<thead>
<tr>
<th></th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you enjoy taking care of your baby?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you and your baby “talk” together during your daily routines?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Are you comfortable and confident in your abilities as a parent?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Is your baby beginning to develop regular sleep patterns?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Do you put your baby on her tummy for short periods of time when she is awake and with you?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Do you have ways to calm your baby when he is crying?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Are you ever afraid that you or other caregivers may hurt the baby?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

**FEEDING YOUR BABY**

<table>
<thead>
<tr>
<th></th>
<th>☐ No</th>
<th>☐ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any questions about feeding your baby?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you feeding your baby anything other than breast milk or formula?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Can you tell when your baby is hungry?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Can you tell when your baby is full?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>
2 MONTH VISIT

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you giving your baby vitamin D drops?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have questions about pumping and storing your breast milk?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you are formula feeding, or providing formula supplementation, answer these questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you using iron-fortified formula?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have questions about using formula, such as how much it costs or how to prepare it?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAFETY

Car and Home Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having any problems using your car safety seat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you always stay within arm’s reach whenever your baby is in or near water?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any questions about things you can do to keep your baby safe at home?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safe Sleep

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your baby sleep on his back?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your baby sleep in a crib?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your baby sleep in your room?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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For more information, go to https://brightfutures.aap.org.
Well Child | 2 Month Visit

<table>
<thead>
<tr>
<th>Accompanied By:</th>
<th>Preferred Language:</th>
<th>Date/Time:</th>
<th>Name:</th>
</tr>
</thead>
</table>

Weight (%): | Length (%): | Weight-for-length (%): | HC (%): | ID Number: |
|------------|-------------|------------------------|--------|-----------|

Vitals (if indicated): Temp: HR: Resp Rate: SpO2: Birth Date: Age: Sex: M F

HISTORY

Concerns and Questions: □ None

Interval History: □ None

Medical History: □ Infant has special health care needs.
Areas reviewed and updated as needed
☐ Past Medical History (See Initial History Questionnaire.)
☐ Surgical History (See Initial History Questionnaire.)
☐ Problem List (See Problem List.)

Medications: □ None

☐ Reviewed and updated (See Medication Record.)

Allergies: □ No known drug allergies

Nutrition:

☐ Breast milk:
   Minutes per feeding: _______ Hours between feedings: _______
   Feedings per 24 hours: _______
   Problems with breastfeeding: 

☐ Formula: Type/brand: _______ Source of water: _______
   Feeding per 24 hours: _______
   Problems with bottle-feeding: 

Selection: □ Regular soft stools □ Normal urine stream

Sleep: □ Normal pattern □ On back □ Safe sleep surface

Behavior: □ No concerns

Activity (tummy time):

Screening Results:
Newborn blood screening: □ Normal
☐ Abnormal

Newborn hearing screening: □ Passed BL □ Referred _______

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: □ None □ Yes:

☐ SOCIAL LANGUAGE AND SELF-HELP
   • Smiles responsively (ie, social smile)

☐ VERBAL LANGUAGE
   • Vocalizes with simple cooing

☐ GROSS MOTOR
   • Lifts head and chest in prone

☐ FINE MOTOR
   • Opens and shuts hands

The recommendations in this form do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original form included as part of the Bright Futures Tool and Resource Kit, 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this form and in no event shall the AAP be liable for any such changes.

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Well Child | 2 Month Visit

SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): □ Social History □ Family History

Changes since last visit:

Smoking household: □ No □ Yes:

Parental support and work-family balance:

Observation of parent-infant interaction:

Parents working outside home: □ One parent □ Both parents

Child care: □ Parent(s) □ Family □ In-home □ Center □ Other:

REVIEW OF SYSTEMS

☐ A 10-point review of systems was performed and results were negative except for any positive results listed below.

**Bold** = Focus area for this Bright Futures Visit

Constitutional: ____________________________ Respiratory: ____________________________ Skin: ____________________________

**Eyes:** ____________________________ **Gastrointestinal:** ____________________________ **Neurological:** ____________________________

**Head, Ears, Nose, and Throat:** ____________________________ **Genitourinary:** ____________________________ **Other:** ____________________________

**Cardiovascular:** ____________________________ **Musculoskeletal:** ____________________________ **Other:** ____________________________

PHYSICAL EXAMINATION

✓ = System examined  **Bold** = Focus area for this Bright Futures Visit

Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.


☐ Head: Normocephalic and atraumatic. No positional skull deformities. Anterior fontanelle open and flat.

☐ Eyes: Fixes and follows. Red reflex present bilaterally. No opacification. Normal funduscopic examination findings.

☐ Ears, nose, and throat: Tympanic membranes with visible light reflex bilaterally. No oral lesions or thrush.

☐ Neck: Supple, with full range of motion without torticollis.

☐ Heart: Regular rate and rhythm. No murmur. Symmetrical femoral pulses.

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing.

☐ Abdomen: Soft, with no palpable masses.

☐ Genitourinary:

□ Normal female external genitalia.

□ Normal male external genitalia, with testes palpable in scrotum bilaterally.

□ Musculoskeletal: Spine straight. Negative Ortolani and Barlow maneuvers.

☐ Neurological: Moves all extremities symmetrically. Normal strength and tone.

☐ Skin: Warm and well perfused. No lesions, birthmarks, or bruising.

Other comments:

ASSESSMENT

☐ Well child  ☐ Normal interval growth (See growth chart.)  ☐ Age-appropriate development
Well Child | 2 Month Visit

ANTICIPATORY GUIDANCE

☐ Discussed and/or handout given

☐ SOCIAL DETERMINANTS OF HEALTH
  • Living situation and food security
  • Family support
  • Child care

☐ NUTRITION AND FEEDING
  • General guidance on feeding and delaying solid foods
  • Hunger and satiety cues
  • Breastfeeding or formula-feeding guidance

☐ PARENT AND FAMILY HEALTH
  • Postpartum checkup
  • Maternal depression
  • Sibling relationships

☐ INFANT BEHAVIOR AND DEVELOPMENT
  • Parent-infant relationship
  • Parent-infant communications
  • Sleeping
  • Media
  • Playtime
  • Fussiness

☐ SAFETY
  • Car safety seats
  • Safe sleep
  • Safe home environment: burns, drowning, and falls

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed

☐ Up-to-date for age

Administered today: _________________________________

Universal Screening:

☐ Maternal depression: Screening tool used: ____________________________ Result: ☐ Neg ☐ Pos:

Newborn blood screening: Result: ☐ Normal ☐ Needs follow-up:

Newborn hearing screening: Result: ☐ Passed BL ☐ Referred right/left/BL ☐ Needs follow-up:

Selective Screening (based on risk assessment) (See Previsit Questionnaire):

☐ BP ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 4 months ☐ Next visit: _______________ ☐ Referral to: _________________________________

PRINT NAME. SIGNATURE

Provider 1

Provider 2

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Here are some suggestions from Bright Futures experts that may be of value to your family.

**HOW YOUR FAMILY IS DOING**

- If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance.
- Find ways to spend time with your partner. Keep in touch with family and friends.
- Find safe, loving child care for your baby. You can ask us for help.
- Know that it is normal to feel sad about leaving your baby with a caregiver or putting him into child care.

**HOW YOU ARE FEELING**

- Take care of yourself so you have the energy to care for your baby.
- Talk with me or call for help if you feel sad or very tired for more than a few days.
- Find small but safe ways for your other children to help with the baby, such as bringing you things you need or holding the baby's hand.
- Spend special time with each child reading, talking, and doing things together.

**FEEDING YOUR BABY**

- Feed your baby only breast milk or iron-fortified formula until she is about 6 months old.
- Avoid feeding your baby solid foods, juice, and water until she is about 6 months old.
- Feed your baby when you see signs of hunger. Look for her to
  - Put her hand to her mouth.
  - Suck, root, and fuss.
- Stop feeding when you see signs your baby is full. You can tell when she
  - Turns away
  - Closes her mouth
  - Relaxes her arms and hands
- Burp your baby during natural feeding breaks.

**YOUR GROWING BABY**

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Hold, talk to, cuddle, read to, sing to, and play often with your baby. This helps you connect with and relate to your baby.
- Learn what your baby does and does not like.
- Develop a schedule for naps and bedtime. Put him to bed awake but drowsy so he learns to fall asleep on his own.
- Don’t have a TV on in the background or use a TV or other digital media to calm your baby.
- Put your baby on his tummy for short periods of playtime. Don’t leave him alone during tummy time or allow him to sleep on his tummy.
- Notice what helps calm your baby, such as a pacifier, his fingers, or his thumb. Stroking, talking, rocking, or going for walks may also work.
- Never hit or shake your baby.

**Helpful Resources:**

Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236
WHAT TO EXPECT AT YOUR BABY’S 4 MONTH VISIT

We will talk about

▪ Caring for your baby, your family, and yourself
▪ Creating routines and spending time with your baby
▪ Keeping teeth healthy
▪ Feeding your baby
▪ Keeping your baby safe at home and in the car

SAFETY

▪ Use a rear-facing-only car safety seat in the back seat of all vehicles.
▪ Never put your baby in the front seat of a vehicle that has a passenger airbag.
▪ Your baby’s safety depends on you. Always wear your lap and shoulder seat belt. Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
▪ Always put your baby to sleep on her back in her own crib, not your bed.
  ◦ Your baby should sleep in your room until she is at least 6 months old.
  ◦ Make sure your baby’s crib or sleep surface meets the most recent safety guidelines.
▪ If you choose to use a mesh playpen, get one made after February 28, 2013.
▪ Swaddling should not be used after 2 months of age.
▪ Prevent scalds or burns. Don’t drink hot liquids while holding your baby.
▪ Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F /49°C.
▪ Keep a hand on your baby when dressing or changing her on a changing table, couch, or bed.
▪ Never leave your baby alone in bathwater, even in a bath seat or ring.

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