

Naval Hospital Oak Harbor Prime Health Center  
Two Week Well Child Visit

Date: \_\_\_\_\_  
Time: \_\_\_\_\_

Provider Note

Interval History:

Medications:

Family History:

Social History:

Development:  Responds to sound     Blinks to bright light     Moves arms and legs equally  
 Lifts head when prone     Regards face     Startles

Physical Exam

Weight: \_\_\_\_\_ kg \_\_\_\_\_ lb \_\_\_\_\_ %ile  
Length: \_\_\_\_\_ cm \_\_\_\_\_ in \_\_\_\_\_ %ile  
OFC: \_\_\_\_\_ cm \_\_\_\_\_ in \_\_\_\_\_ %ile

Vital Signs     N/A

Temp: \_\_\_\_\_    HR: \_\_\_\_\_  
RR: \_\_\_\_\_    O2 Sat: \_\_\_\_\_

Pain: \_\_\_\_\_ (0-10)

NI    Abn

General Appearance:  
  Head:  
  Eyes:  
  ENT:  
  Neck:  
  Chest:  
  Heart:  
  Abdomen:  
  Genitals:  
  Musculoskeletal:  
  Skin:  
  Neuro:

Newborn hearing screen results:     pass     refer  
Metabolic screen (1st) results:     neg     pos     pending

Assessment

Plan

Anticipatory Guidance

Repeat State Metabolic Screen (PKU)

Other: \_\_\_\_\_

Follow-up: 2 months of age    other: \_\_\_\_\_

Addressograph

\_\_\_\_\_  
Examiner's Signature/Name Stamp

**Two Week Well Child Visit  
Parent Questionnaire**

1. What issues were there during pregnancy? (check all that apply)
  - Diabetes
  - Smoking
  - Drugs, including medications (specify):
  - Infection (specify):
  - Other (specify):
  - High Blood Pressure
  - Alcohol Use
  
2. Type of Delivery (circle): Vaginal / Cesarean Section (C/S)  
If C/S, give reason:
  
3. What was your baby's birth weight?
  
4. Was the delivery complicated by (check all that apply):
  - Meconium in the amniotic fluid
  - Other (specify):
  - Maternal Fever
  
5. What problems did your baby have during the first week? (check all that apply)
  - Jaundice
  - Need for antibiotics
  - Other (specify):
  - Feeding problems
  - Oxygen requirement
  - Excessive weight loss
  - Low blood sugar
  
6. Describe your baby's diet:
  - Breastfeeds \_\_\_\_\_ times per day.
  - Formula feeds \_\_\_\_\_ ounces per day. Name of Formula: \_\_\_\_\_
  
7. Describe your baby's elimination pattern:
  - Stools (how many, appearance): \_\_\_\_\_
  - Urine (# wet diapers/day): \_\_\_\_\_
  
8. What position do you put your baby to sleep?     Back         Side         Stomach
  
9. Is there is a gun in the home? Yes/No
  
10. Are there any smokers in the household? Yes/No
  
11. Does your home have working smoke detectors? Yes/No
  
12. Do you have a working thermometer (non-mercury)? Yes/No
  
13. Does your baby ride in a car seat in the back seat, facing backwards? Yes/No
  
14. Do you put the crib rails up whenever you leave your baby in its crib? Yes/No
  
15. Do you ever leave your baby alone on tables or beds? Yes/No
  
16. Have you checked the temperature of the hot water where you live? Yes/No
  
17. Do you fear for the safety of yourself or members of your family? Yes/No
  
18. What questions do you have for your baby's provider today?