2 Months Questions

Patient Name:	DOB:	Date:

Any questions or concerns today? Please circle all that apply.

Eating	Y	N
Elimination (voiding/stooling)	Y	N
Sleeping	Y	N
Developmental	Y	N
Hearing/Vision	Y	N
Skin	Y	N
Vaccines	Y	N
Other	Y	N
Any family changes or stressors since last visit?	Y	N
Has your baby been fussier than you expected?	Y	N
Can you usually tell what your baby needs?	Y	N
Do you have a rear facing car seat?	Y	N
Are you returning to work/school?	Y	N
Are you getting enough rest?	Y	N
Do you feel tired or blue?	Y	N
Does your baby have any exposure to smoke?	Y	N
Do you have working smoke detectors and carbon monoxide detectors?	Y	N

Food Insecurity & Transportation Questions (mark your answer):

- Within the past 12 months, you worried that your food would run out before you got money to buy more.
  - Often true
  - Sometimes true
  - Never true
- Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
  - Often true
  - Sometimes true
  - Never true
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living (mark all that apply)?
  - Yes, it has kept me from medical appointments or getting medications
  - Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
  - No

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Patient Name: DOB:

ASQ-3

2 Month Questionnaire

1 month 0 days through 2 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	◯	◯	◯	____
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	◯	◯	◯	____
3. When you speak to your baby, does she make sounds back to you?	◯	◯	◯	____
4. Does your baby smile when you talk to him?	◯	◯	◯	____
5. Does your baby chuckle softly?	◯	◯	◯	____
6. After you have been out of sight, does your baby smile or get excited when she sees you?	◯	◯	◯	____

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	◯	◯	◯	____
2. When your baby is on her tummy, does she turn her head to the side?	◯	◯	◯	____
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	◯	◯	◯	____
4. When your baby is on her back, does she kick her legs?	◯	◯	◯	____
5. While your baby is on his back, does he move his head from side to side?	◯	◯	◯	____
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	◯	◯	◯	____

GROSS MOTOR TOTAL ____

E101020200

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Is your baby's hand usually tightly closed when he is awake? (*If your baby used to do this but no longer does, mark "yes."*)	◯	◯	◯	____
2. Does your baby grasp your finger if you touch the palm of her hand? 	◯	◯	◯	____
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	◯	◯	◯	____
4. Does your baby touch her face with her hands?	◯	◯	◯	____
5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? 	◯	◯	◯	____ *
6. Does your baby grab or scratch at her clothes?	◯	◯	◯	____

FINE MOTOR TOTAL ____

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	◯	◯	◯	____
2. When you move around, does your baby follow you with his eyes?	◯	◯	◯	____
3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?	◯	◯	◯	____
4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?	◯	◯	◯	____
5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	◯	◯	◯	____
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	◯	◯	◯	____

PROBLEM SOLVING TOTAL ____

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	◯	◯	◯	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	◯	◯	◯	___
3. Does your baby smile at you?	◯	◯	◯	___
4. When you smile at your baby, does she smile back?	◯	◯	◯	___
5. Does your baby watch his hands? 	◯	◯	◯	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	◯	◯	◯	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: ◯ YES ◯ NO

2. Does your baby move both hands and both legs equally well? If no, explain: ◯ YES ◯ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ◯ YES ◯ NO

OVERALL *(continued)*

4. Has your baby had any medical problems? If yes, explain: ◯ YES ◯ NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ◯ YES ◯ NO

6. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

BRIGHT FUTURES HANDOUT ▶ **PARENT**

2 MONTH VISIT

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.

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.

If Breastfeeding

- Feed your baby on demand. Expect to breastfeed 8 to 12 times in 24 hours.
- Give your baby vitamin D drops (400 IU a day).
- Continue to take your prenatal vitamin with iron.
- Eat a healthy diet.
- Plan for pumping and storing breast milk. Let us know if you need help.
  - If you pump, be sure to store your milk properly so it stays safe for your baby. If you have questions, ask us.

If Formula Feeding

- Feed your baby on demand. Expect her to eat about 6 to 8 times each day, or 26 to 28 oz of formula per day.
- Make sure to prepare, heat, and store the formula safely. If you need help, ask us.
- Hold your baby so you can look at each other when you feed her.
- Always hold the bottle. Never prop it.

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.

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

2 MONTH VISIT—PARENT

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.

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

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Acetaminophen/Ibuprofen Dosage

GROW PEDIATRICS

Acetaminophen (Tylenol® or another brand)

Give every 6 hours as needed.
Do not give more than 4 doses in 24 hours.

Weight in pounds (lbs.)	Acetaminophen liquid 160mg*/5ml *Double check concentration
5-6.5 lbs.	40 mg (1.25 ml)
6.5-8 lbs.	48 mg (1.5 ml)
8-10.5 lbs.	64 mg (2 ml)
10.5-13 lbs.	80 mg (2.5 ml)
13-16 lbs.	96 mg (3 ml)
16-20.5 lbs.	120 mg (3.75 ml)
20.5-26 lbs.	160 mg (5 ml)
26-32 lbs.	192 mg (6 ml)
32-41 lbs.	240 mg (7.5 ml)
41-53 lbs.	325 mg (10 ml)
53-65 lbs.	400 mg (12.5 ml)
65-90 lbs.	480 mg (15 ml)
90 lbs. and over	650 mg (20 ml)

Ibuprofen (Advil®, Motrin®, or another brand)

Give every 6 to 8 hours as needed; **always** with food.
Do not give more than 4 doses in 24 hours.

Weight in pounds (lbs.)	Ibuprofen suspension 100mg*/5ml *Double check concentration
8-14 lbs.	50 mg (2.5 ml)
14-20 lbs.	75 mg (3.75 ml)
20-25 lbs.	100 mg (5 ml)
25-30 lbs.	125 mg (6.25 ml)
30-38.5 lbs.	150 mg (7.5 ml)
38.5-50 lbs.	200 mg (10 ml)
50-60 lbs.	250 mg (12.5 ml)
60-72 lbs.	300 mg (15 ml)
72-82.5 lbs.	350 mg (17.5 ml)
82.5-94 lbs.	400 mg (20 ml)
94-105 lbs.	450 mg (22.5 ml)
105-115 lbs.	500 mg (25 ml)
115-126 lbs.	550 mg (27.5 ml)
126 lbs. and over	600 mg (30 ml)

Ibuprofen should NOT be given to children under 6 months of age.

Questions?

This sheet is not specific to your child but provides general information. If you have any questions, please call your clinic or pharmacy.