Patient Name_____DOB_____

# Risk Assessment 2 Months

| | | | |
|---|---|---|---|
| Concerns about how child sees | No | Yes | Concerns |
| Pushes head up when lying on tummy | Yes | No | Comment |
| Moves both arms and legs together | Yes | No | Comment |
| Coos | Yes | No | Comment |
| Looks at you | Yes | No | Comment |
| Smiles | Yes | No | Comment |
| Comforts self (brings hands to mouth) | Yes | No | Comment |
| Has different types of cries to show hunger or when tired | Yes | No | Comment |

**Hip dyplasia risk:**

| | | | | |
|---|---|---|---|---|
| Was baby breech in the last month of pregnancy? | No | Yes | Unknown | Comment |
| Was your child a multiple (twin, triplet, etc?) | No | Yes | Unknown | Comment |
| Is there a family history of hip dysplasia? | No | Yes | Unknown | Comment |
| Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?) | No | Yes | Unknown | Comment |

**Anticipatory Guidance:**

| | | | | |
|---|---|---|---|---|
| Can sleep 4-5 hours per night | Yes | No | Comment | |
| Sleeps on back | Yes | No | Comment | |
| Spends time on tummy | Yes | No | Comment | |
| Breast or bottle | Breast Milk | Formula | Both | Comment |
| Vitamin D supplement regularly | Yes | No | N/A | |
| Regular car seat use | Yes | No | Comment | |
| Car seat rear facing | Yes | No | Comment | |
| Home and car are smoke-free environment | Yes | No | Comment | |
| Drink hot liquids while carrying or holding baby | No | Yes | Comment | |