



Well Baby Check: 4 month visit questionnaire

Interval History:

Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No Yes

Has your baby had any reactions to vaccinations given in the past? No Yes

Development:

Can your baby follow your face or an object in a 180° arc? Yes No

Does your baby turn toward voices or sounds? Yes No

Do you have any concerns about how your baby sees or hears? No Yes

Does your baby lift his/her head and chest when lying on his/her tummy? Yes No

Does your baby squeal, laugh and initiate interactions? Yes No

Can your baby reach for and grasp objects? Yes No

Can your baby bring his/her hands together? Yes No

When you place your baby in a sitting position, is his/her head steady? Yes No

Does your baby roll over? Yes No

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

Does your baby watch TV? No Yes

Does your home have a working smoke detector? Yes No

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes No N/A

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes No

Do you always put your baby to sleep on her/his back? Yes No

Do you always stay with your baby when she/he is in the bathtub? Yes No

Do you always place your baby in a rear-facing car seat in the back seat? Yes No

Is your car seat the right one for the age and size of your baby? Yes No

Does your baby spend time in a home where a gun is kept? No Yes Skip

If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes No N/A

Does your baby spend time with anyone who smokes? No Yes

Sleep:

How many hours does your baby sleep at night? _____ hours

How many hours does your baby nap throughout the day? _____ hours

Parental Support:

During the past 2 weeks, how often have you been bothered by the following problems:

Feeling down, depressed, irritable, or hopeless?

[Not at all] [Several days] [More than half the days] [Nearly every day]

Little interest or pleasure in doing things?

[Not at all] [Several days] [More than half the days] [Nearly every day]

Nutrition/Physical Activity:

For Breastfeeding: How many minutes of feeding per side? _____ minutes

For formula/bottle feeding: How many ounces per feeding? _____ oz

If you are giving formula, what brand are you using? _____

How often does your baby feed? Every _____ hours

How many breast milk/formula feedings in 24 hours? _____ feedings

Have you started any solid foods for your baby? No Yes

Do you give your baby a bottle of anything except formula or breast milk? No Yes

Do you have any concerns about your baby's feeding? No Yes

Elimination:

Does your baby have bowel movements on a regular basis

with a normal (soft) consistency? Yes No

Please list any medications or supplements your baby is taking, including vitamin D:

Who lives in the home with your baby? _____

Who provides daytime care for your baby? _____

Please list any major family medical issue: _____

Please list any known Allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

Patient Name

Questionnaire • Well Baby Check 4 Month

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Date of Birth

Parent or Guardian Signature: _____

Date: _____

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <input type="checkbox"/> Patient Declined the SHA </div>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name:		Date:	

Ver.12-12-17 V2