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

**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? Yes No
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?
__________________________________________________________________________________________________
__________________________________________________________________________________________________
Parent or Guardian Signature: ____________________________

Date: _________________

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counseled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Tobacco Exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Physical Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Dental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Patient Declined the SHA

PCP's Signature

Print Name: ______________________

Date: ______________________

Ver.12-12-17 V2