Medical Record Number

Patient Name

Patient Label

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?

_____

_____

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

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