4 Month Well Child Check Name_____

Allergies_____Current Meds_____

Is your baby healthy?	Yes	No_____
Do you feel your baby is developing normally?	Yes	No_____
Do you think your baby can hear?	Yes	No_____
Do you think your baby can see?	Yes	No_____
Do your baby's eyes turn inward or outward or cross?	No	Yes_____
Does your baby have normal stools?	Yes	No_____
Does your baby sleep a 4-6 hour stretch at night?	Yes	No_____
Is there a patient/ family history of an immunization reaction?	**No**	**Yes**_____
If breastfeeding—are you having any problems?	No	Yes_____
How often is your baby nursing?		_____
If formula feeding—Type of formula?		_____
How many ounces/how often?		_____
Is your baby having any feeding problems?	No	Yes_____
Has your baby started solids?	**No**	**Yes**
Are you feeling depressed or "down" much of the time?	No	Yes_____
Has there been any recent change to your family structure?	No	Yes_____
Does your home have a safe, adequate heat source?	Yes	No
Does anyone in your household smoke ?	No	Yes
Is your baby in childcare?	No	Yes_____
Does your baby drink juice? If so, how many oz/day?	No	Yes_____
Is there a family history of food allergies?	No	Yes_____
Where does your baby sleep?		_____
Is your hot water heater turned down to 120 degrees?	Yes	No
Does your house have smoke detectors?	Yes	No
Do you have working carbon monoxide detectors?	Yes	No

Do you have any other concerns?_____

<u>Development</u> (Do not complete if given the Ages and Stages Questionnaire)

Does your baby babble or coo?	Yes	No
Does your baby recognize your voice?	Yes	No
Does your baby smile, laugh, squeal?	Yes	No
Does your baby's eyes follow an object 180 degrees?	Yes	No
When on his/her stomach, does your baby raise his/her head?	Yes	No
Does your baby roll over (back to front)?	Yes	No
Does your baby control his/her head when sitting?	Yes	No
When pulling your baby to a sitting position by his/her hands does her/his head lag back?	Yes	No