

Well-check questionnaire

4 month well-check

Patient name: _____ **DOB:** _____ **Today's date:** _____

Medications: _____ **Allergies:** _____

Mother's maiden name: _____

Are you breast or formula feeding? _____

Name of formula: _____ Ounces per feeding: _____

Of wet diapers a day: _____ # Of stools a day: _____

- | | | |
|--|-----------------------------|------------------------------|
| Do you have any concerns with feedings? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Has your baby started eating cereals? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby drinking anything other than breastmilk or formula? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have a strong family history of food allergies? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have concerns with your baby's bowel movements? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have concerns with your baby's sleep habits? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your baby sleep in a crib or bassinet? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your baby go to a daycare home or center? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your baby sleep on his/her back? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby always in a car seat when riding in a vehicle? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your hot water heater turned down to 120? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your home have smoke and carbon monoxide detectors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby exposed to secondhand smoke at home, in cars or at daycare? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have outlet protectors and safety gates? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Does your baby:

- | | | |
|---|-----------------------------|------------------------------|
| Laugh or chuckle out loud? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Follow people or objects with his/her eyes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Respond to voices or sounds? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Reach or grab for objects with either hand? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Briefly grasp an object or toy with his/her hand? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Roll over or attempt to roll over? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do "tummy time" during play? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Is your baby:

- | | | |
|--------------------------|-----------------------------|------------------------------|
| Quick to agitation? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Difficult to soothe? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Irritable with feedings? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Any questions or concerns: _____