4 Month Old Questions **Name, Date of birth _____**

Who is the baby here with today? _____

GENERAL:

Illnesses, injuries, surgeries, hospitalizations since last visit? _____

Medications: _____

Medication allergies: _____

Immunization reactions: _____

Maternal medications: _____

Is your child taking vitamins? (Circle what applies) Fluoride, Multi-vitamin, None

SOCIAL:

Changes in child's environment? _____

Who lives with the child in your home? #____Mom, #____ Dad , #____ Brother, # ____ Sister, _____other

Water source: CITY, WELL, BOTTLED

Tobacco exposure: YES, NO

Pets?_____

Daycare: YES, NO

FEEDING:

BREASTFEEDING? YES, NO _____

FORMULA FEEDING? YES, NO _____

Problems spitting up? YES, NO _____

ELIMINATION: Any issues urinating or with bowel movements? _____

SLEEP: How many hours without waking through the night?_____

BEHAVIOR (circle what applies) No problems, happy most of the time, Frequently fussy, Clingy, Difficult to console

DEVELOPMENT:

1. Reaches and grasps: YES, NO

2. Brings hands together: YES, NO

3. Holds head steady: YES, NO

4. Lifts head when on belly: YES, NO

5. Pushes up on hands/elbows: YES, NO

6. Rolls front to back: YES, NO

7. Rolls back to front: YES, NO

8. Bears weight on feet: YES, NO

9. Tracks an object 180°: YES, NO

10. Babbles/Coos: YES, NO

11. Smiles/Laughs: YES, NO

12. Turns to sound: YES, NO

13. Responds to affection: YES, NO

14. Indicates pleasure/displeasure: YES, NO

15. Do you think that your child hears well? YES, NO

16. Do you think that your child sees well? YES, NO

17. Are you reading to your child? YES, NO

{International Travel: Exposure to anyone who has traveled outside the United States in last 60 days: YES, NO