Well Child Check: 4 Month

Your Child's Name: __________________________________________________

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Can your child lift her head when on tummy? Yes No Unsure
Can your child hold the head steady as you pick him up? Yes No Unsure
Does your child reach for objects? Yes No Unsure
Does your child hold objects briefly? Yes No Unsure
Does your child coo (make "ooh, “ahh” noises)? Yes No Unsure
Does your child smile? Yes No Unsure
Does your child laugh or squeal? Yes No Unsure
Does your baby drink breast milk or formula? Breast milk Formula Both
If you are giving formula how many ounces does your child take in 24 hours? ________________ oz.
Type of formula? ________________________________________________________________________

Do you have a regular bedtime for your child? Yes No Unsure
Was your child born after the 37th week of pregnancy? Yes No Unsure
Did your child weigh more than 5 pounds 8 ounces (2500gm) at birth? Yes No Unsure

Has mom been feeling sad, anxious, hopeless or depressed? No Yes Unsure
Is your child on any medications or supplements, including vitamins? If so, please list below:
_____________________________________________________________________________________

Who provides daytime care for your child? __________________________________________________________________

Do you have any concerns about your child’s development, or any other concerns you would like to discuss with your provider? If so, please describe:
_____________________________________________________________________________________
_____________________________________________________________________________________

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