4 MONTH VISIT

This section to be completed by the parent

Patient Name	**Date**	
Are concerned about your baby's…		
1. Feedings Breast Y N Formula Y N Both Y N	**YES**	**NO**
2. Excessive spitting or vomiting	**YES**	**NO**
3. Bowel movements	**YES**	**NO**
4. Straining with stools	**YES**	**NO**
5. Straining or crying while urinating	**YES**	**NO**
6. Congestion or breatning	**YES**	**NO**
7. Skin color or rash	**YES**	**NO**
8. Excessive crying	**YES**	**NO**
9. Overall development	**YES**	**NO**
10. Sleep habits	**YES**	**NO**
11. Have you been sad, depressed or crying excessively	**YES**	**NO**
Does your child...		
12. Sleep on his/her back	**YES**	**NO**
13. Sleep in a room, alone	**YES**	**NO**
14. Smile when you approach	**YES**	**NO**
15 Cry when you walk out of the room	**YES**	**NO**
16. Coo, babble, laugh or squeal	**YES**	**NO**
17. Turn head toward direction of sound	**YES**	**NO**
18. Move all extremities well	**YES**	**NO**
19. Roll over (either way)	**YES**	**NO**
20. Try to bat at objects	**YES**	**NO**
21. Ride in a rear facing car seat	**YES**	**NO**
22. Do you know infant CPR?	**YES**	**NO**
23. Do you have smoł ke alarms	**YES**	**NO**
24. Were there any problems with the first immunization?	**YES**	**NO**
25. Is your child exposed to cigarette smoke?	**YES**	**NO**
26. Is your child attending day care?	**YES**	**NO**

Do you have concerns you want to discuss?

For office use only

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