4 month – well child care **Patient Name:_____D.O.B_____**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? _____

Does your child attend daycare?_____ ▢ Yes ▢No

Development

Makes sounds like “oooo” and “aahh”_____ ▢ Yes ▢No
Makes sounds back when you talk to them_____ ▢ Yes ▢No
Holds head steady without support when you are holding them ▢ Yes ▢No
Holds a toy when you put it in their hand_____ ▢ Yes ▢No
Uses their arms to swing at toys_____ ▢ Yes ▢No
Brings hands to mouth_____ ▢ Yes ▢No
Pushes up onto elbows/forearms when on tummy_____ ▢ Yes ▢No
If hungry, opens mouth when they see breast or bottle_____ ▢ Yes ▢No
Looks at their hands with interest_____ ▢ Yes ▢No
Turns head toward the sound of your voice_____ ▢ Yes ▢No
Smiles on their own to get your attention_____ ▢ Yes ▢No
Chuckles when you try to make them laugh_____ ▢ Yes ▢No
Looks at you, moves, or makes sounds to _____ ▢ Yes ▢No
get or keep your attention

Nutrition

If started, what types of baby food are being given?_____ ▢Breast Fed ▢Formula

How much and how frequent?_____

If breastfeeding, is the baby receiving a vitamin D supplement? ▢ Yes ▢No

Wakes for feeds overnight?_____ ▢ Yes ▢No

Bowel habits

How many stools does you child have per day? _____

What do the stools look like (soft, seedy, loose)? _____

Sleep Pattern

Sleeps on back?_____ ▢ Yes ▢No

Safety

Is your child's car seat rear facing and in the back seat?_____ ▢ Yes ▢No
Is your child exposed to tobacco smoke?_____ ▢ Yes ▢No
Are there any improperly stored firearms in the home?_____ ▢ Yes ▢No
Is the hot water temperature set low enough
to prevent accidental burns?_____ ▢ Yes ▢No
Are there working smoke detectors in the home?_____ ▢ Yes ▢No

Please share any concerns that you have about your child here:

_____

_____

_____

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Please complete both sides of this form