4 Month Pre-Visit Questionnaire

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME: _____ DATE OF BIRTH:_____

YOUR NAME:_____RELATIONSHIP:_____

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:_____
_____
_____

Does your child have any allergies? YES/NO If yes, please list:_____
Does your child take any medications? YES/NO If yes, please list:_____
Has your child seen any other health care providers? YES/NO If yes, please list:_____

FEEDING/NUTRITION

Please describe your child's diet (breast milk or formula, type, amount, frequency, supplements)

_____
_____
_____

CHILDCARE

Does your child attend daycare? YES/NO If yes, where?_____

BEHAVIOR/SOCIAL

Review of Systems	Never	Sometimes	All the time
Does your child cry more than normal?			
Does your child have trouble sleeping?			
Does your child have a hard time calming down?			
Risk Assessment			
Has a family member's drinking or drug use ever had a negative effect on your child?			
Does your child live with or spend time with anyone who smokes?			
In the past year did you ever worry that your food would run out before you could afford to buy more?			

DEVELOPMENTAL MILESTONES: Please put a check beside the things your child is able to do.

____ Smiles spontaneously
____ Keeps head steady held
____ Rolls over
____ Grabs things
____ Can calm down by themselves
____ Looks both ways
____ Turns to sounds
____ Laughs