UW Medicine
UW NEIGHBORHOOD CLINICS

Four Month Old Well Child Visit

Baby's Name ______________________________ Baby's Birth Date ____________________

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	Yes	No
Is your baby being breastfed exclusively?	( )	( )
Is your baby feeding well?	( )	( )
How often is your baby feeding?		
How long/How many ounces?		
Is your baby stooling comfortably?	( )	( )
If breastfed, is your baby getting a daily vitamin?	( )	( )

Social Screening	Yes	No
What are your current child-care arrangements?		
Is your mood good overall?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Is your baby in a car seat in the backseat facing backwards when in the car?	( )	( )
Is your water heater set to 120° or lower?	( )	( )
Is your home free of risky toys, such as infant walkers and small toys that are choking hazards?	( )	( )

Sleep	Yes	No
Does your baby sleep on her/his back/side?	( )	( )
Does your baby sleep in her/his own crib?	( )	( )

Developmental Screening	Yes	No
Does your baby coo?	( )	( )
Does your baby laugh and squeal?	( )	( )
Does your baby follow people or objects with her/his eyes all the way across the room?	( )	( )
Does your baby hold her/his head and chest up while on her/his stomach?	( )	( )
Does your baby roll over?	( )	( )
Does your baby play with her/his hands by touching them together?	( )	( )
Does your baby reach for and grasp objects?	( )	( )

Has your baby had any significant illnesses since the last time we saw you? If yes, please describe:

____

____

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

____

____

Current concerns not listed above:

____

____