

# 4-Month-Old Well Child Visit

Baby's Name: \_\_\_\_\_ Baby's Age: \_\_\_\_\_ Date: \_\_\_\_\_

Person completing the form \_\_\_\_\_ Relationship to the patient \_\_\_\_\_

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Nutrition:	Yes	No
Is your baby feeding well?	<input type="checkbox"/>	<input type="checkbox"/>
Is your baby breastfed?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, how often? _____		
Is your baby formula fed? If yes:	<input type="checkbox"/>	<input type="checkbox"/>
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		
Are you giving your baby vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you offering anything else to your baby to eat or drink?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

Preventative Health/Risk Factors:	Yes	No
Does your child sleep only on his/her back?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep in his/her own bassinet or crib?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child always ride in a car seat, in the back seat, facing backwards?	<input type="checkbox"/>	<input type="checkbox"/>
Do you, anyone who cares for your child, or anyone in your home smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Is your home free of infant walkers?	<input type="checkbox"/>	<input type="checkbox"/>
Is your home free of small toys that are choking hazards?	<input type="checkbox"/>	<input type="checkbox"/>
Is your water heater set to less than 120 degrees?	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in enrolling your child in daycare?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, do you need assistance to find a suitable program?	<input type="checkbox"/>	<input type="checkbox"/>

### Developmental Surveillance:

Social/Emotional Development:	Yes	No
Can calm down on own?	<input type="checkbox"/>	<input type="checkbox"/>
Smiles to get your attention?	<input type="checkbox"/>	<input type="checkbox"/>
Wants you to play?	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

**UW Medicine**  
 Harborview Medical Center – University of Washington Medical Center  
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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<b>Communicative Development:</b>	<b>Yes</b>	<b>No</b>
Babbles?	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>Cognitive Development:</b>	<b>Yes</b>	<b>No</b>
Likes to cuddle?	<input type="checkbox"/>	<input type="checkbox"/>
Lets you know when happy or not?	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>Physical Development:</b>	<b>Yes</b>	<b>No</b>
Pulls to sit with no head lag?	<input type="checkbox"/>	<input type="checkbox"/>
Bears weight on legs?	<input type="checkbox"/>	<input type="checkbox"/>
Pushes chest up to elbows?	<input type="checkbox"/>	<input type="checkbox"/>
Good head control?	<input type="checkbox"/>	<input type="checkbox"/>
Moves both sides equally?	<input type="checkbox"/>	<input type="checkbox"/>
Begins to roll and reach for objects?	<input type="checkbox"/>	<input type="checkbox"/>

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