4 Month Health Maintenance Form

Patient Name _____

Who accompanied child today? _____
(name and relationship to child)

_____

Who does child live with? _____

_____

Any Chronic health problems? _____

_____

Concerns about the above health problems? _____

_____

New or recent health concerns? _____

_____

Feedings:
Breastfeeding:
How many times per day do you breastfeed? _____

Bottle Feeding:
How many ounces per day? _____

Brand of Formula used? _____

Any juices or solids started? _____

If yes, what type? _____

Any concerns with stooling or urination? _____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Sleep pattern:

Average number hours of sleep in 24 hours: _____

Frequency of nighttime awakenings: _____

Number of naps: _____

Length of naps: _____

Where does your child sleep? _____

Are there any smokers in the household? _____

Medications:

Please list current medications: _____

_____

_____

_____

Any allergies to medicine? _____

_____

Does your baby:

Hold head up 90 degrees when on tummy? (Can look straight ahead while on tummy?)	Yes	No
Lifts chest off the floor using forearms?	Yes	No
Have steady head control when upright?	Yes	No
Roll over from Front to Back?	Yes	No
Open hands to hold objects, play with hands?	Yes	No
Follow you with his/her eyes 180 degrees?	Yes	No
Vocalize, coo, squeal or laugh?	Yes	No
Smile spontaneously?	Yes	No
Initiate social interaction with you?	Yes	No

If you do not understand any of these questions, please ask your nurse.