CHILDREN FIRST
DUMFRIES PEDIATRICS

Well Child Check: 4 Month

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Can your child lift her head when on tummy?	Yes	No	Unsure
Can your child hold the head steady as you pick him up?	Yes	No	Unsure
Does your child reach for objects?	Yes	No	Unsure
Does your child hold objects briefly?	Yes	No	Unsure
Does your child coo (make "ooh, "ahh" noises)?	Yes	No	Unsure
Does your child smile?	Yes	No	Unsure
Does your child laugh or squeal	Yes	No	Unsure
Does your baby drink breast milk or formula?	Breast milk	Formula	Both

If you are giving formula how many ounces does your child take in 24 hours?_____ oz.

Type of formula?

_____

Do you have a regular bedtime for your child?	Yes	No	Unsure
Was your child born after the 37th week of pregnancy?	Yes	No	Unsure
Did your child weigh more than 5 pounds 8 ounces (2500gm) at birth?	Yes	No	Unsure

Has mom been feeling sad, anxious, hopeless or depressed?	No	Yes	Unsure

Is your child on any medications or supplements, including vitamins?

If so, please list below:

_____

Who provides daytime care for your child? _____

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?

If so, please describe:

_____

_____