

Name: _____ Date of birth: _____

Health Status Questionnaire – 4 Months

Baby lives with: mother father both parents other: _____

Childcare: daycare babysitter stays at home other: _____

Breastfeeding? Y N Every ____ hours For ____ minutes per side

Formula feeding? Y N Formula: _____

____ oz every ____ hours, ____ oz total 24 hours

If at least ½ the feedings are breastmilk, giving vitamin D supplement? Y N

Any problems feeding? Y N _____

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Lift his/her head and chest when laying on tummy? Y N

Roll over at least one way? Y N

Control his/her head when in sitting position? Y N

Attempt to grasp objects with hands? Y N

Bring hands together? Y N

Move both eyes completely from one side to the other? Y N

Smile, laugh, squeal and coo? Y N

Seek eye contact? Y N

Turns to noise? Y N

Passive smoke exposure: Y N Car seat use: Y N

Smoke detectors: Y N Fire extinguishers: Y N

Do you have any concerns about your baby? _____
