



# Health Maintenance Questionnaire

# 4 MONTHS

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION	PHYSICIAN'S COMMENTS
<p><b>HISTORY</b></p> <p>Describe any recent injuries or illnesses: _____</p> <p>List medications taken routinely: <input type="checkbox"/> none</p> <p>Note any new stresses in the family: _____</p> <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Have you gone out without baby?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are siblings adjusting to baby OK?</p> <p>Is your baby in day care? <input type="checkbox"/> No</p> <p><input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other:</p> <p>How many kids? _____</p> <p>Are there smokers in your baby's home or daycare?</p> <p><input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room</p> <p><b>NUTRITION</b></p> <p><b>FORMULA FEEDING:</b></p> <p>How many ounces in 24 hrs? _____ What formula? _____</p> <p><b>BREAST FEEDING:</b></p> <p>How many times does baby nurse in 24 hours? _____</p> <p>How many minutes is each feeding? _____</p> <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Is baby fed on demand?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you given supplemental formula?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you pumping breast milk?</p> <p>How many of each per day: spit ups _____ wets _____</p> <p>How often does baby pass stool? _____</p>	<p>☞ Note infants interest in environment / eating / stimulation</p> <p><input type="checkbox"/> Discussed risks of 2<sup>nd</sup> hand smoke.</p> <p><b>Shaded items are new for the 4 mo check -up.</b></p> <p><b>GENERAL FEEDING RECOMMENDATIONS</b></p> <p><input type="checkbox"/> Formula with iron until age 1.</p> <p><input type="checkbox"/> Introduce solids between 4-6 months old.</p> <p><input type="checkbox"/> Start with #1 baby food jars.</p> <p><input type="checkbox"/> Vitamins only if prescribed.</p> <p><b>BREAST FEEDING RECOMMENDATIONS</b></p> <p><input type="checkbox"/> Should sleep more at night, but expect at least one night feeding.</p> <p><input type="checkbox"/> 8-12 feedings in 24 hrs is typical.</p> <p><input type="checkbox"/> Baby is easily distracted, not disinterested.</p> <p><input type="checkbox"/> Nurse in a quiet place.</p> <p><input type="checkbox"/> Don't restrict feedings / Feed on demand.</p> <p><input type="checkbox"/> Expect growth spurt at 6 months.</p> <p><input type="checkbox"/> Back to work? Pump and freeze milk properly.</p> <p><input type="checkbox"/> Mom should not diet. Drink to thirst.</p> <p><b>STOOLING EXPECTATIONS</b></p> <p><input type="checkbox"/> <b>BREAST FED:</b> Stools may occur several times per day or only once per week. This is normal if it is soft. Stools will change if formula is used.</p> <p><input type="checkbox"/> <b>FORMULA FED:</b> Stool frequency is variable, but should not be hard balls.</p>

PHYSICAL EXAM		LAB	IMMUNIZATIONS
Ht _____	Wt _____		<p><input type="checkbox"/> Given at Health Department</p> <p>Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what? _____</p> <p><input type="checkbox"/> DTaP <input type="checkbox"/> HepB</p> <p><input type="checkbox"/> IPV <input type="checkbox"/> Hib</p> <p><input type="checkbox"/> Comvax <input type="checkbox"/> Other:</p> <p><input type="checkbox"/> Prevnar</p>
HC _____	VS: _____		
<p>Check if normal:</p> <p><input type="checkbox"/> Head/Fontanel</p> <p><input type="checkbox"/> Eyes/Red reflexes</p> <p><input type="checkbox"/> Ears</p> <p><input type="checkbox"/> Nose</p> <p><input type="checkbox"/> Mouth</p> <p><input type="checkbox"/> Throat</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Chest</p>	<p><input type="checkbox"/> Lungs</p> <p><input type="checkbox"/> Heart</p> <p><input type="checkbox"/> Femoral pulses</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Genitalia</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Extremities</p> <p><input type="checkbox"/> Skin</p> <p><input type="checkbox"/> Neurologic</p>		

NOTE EXAM ABNORMALITIES HERE

### ASSESSMENT

- NORMAL GROWTH and DEVELOPMENT. More information on other side.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### PLAN

- Follow up at 6 months for Health Review.  Anticipatory handouts given.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's development or behavior?	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby turn his/her head toward your voice? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he follow your face or an object with his/her eyes through 180 degrees?	
<b>M O T O R</b>	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby hold his/her head straight when pulled from lying to sitting position? <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby push his/her chest off the floor and hold the head high? <input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he trying to roll over? <input checked="" type="checkbox"/> <input type="checkbox"/> Will baby open his/her hands when at rest? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he reach for and bat at objects or the mobile?
<b>L A N G U A G E</b> <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Do you talk, read and sing to baby?	
<b>S O C I A L</b>	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he initiate social contact by smiling, cooing, laughing and squealing? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your baby starting to experience "stranger anxiety?" <input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting to enjoy peek-a-boo, so-big and pat-a-cake games? <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby seem to be "teething?" (Teeth usually appear after 6 months.)
<b>S L E E P</b>	How many hours does baby sleep at a time? _____ <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Have you established a bedtime routine? <input checked="" type="checkbox"/> <input type="checkbox"/> Can baby comfort self and fall asleep without feeding? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you put him/her down when drowsy to teach self-quieting? <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby suck his/her thumb? (This is usually established by now if it will be a habit.) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you put baby down on his/her back? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid bulky bedding in the crib?  Where does baby sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 4 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/>	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage and small parts that may cause choking?  <input checked="" type="checkbox"/> <input type="checkbox"/> Is baby's car seat rear facing in the back seat? → <input checked="" type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid drinking hot liquids while holding your baby? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor baby closely around young siblings or pets? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid putting baby in the car seat / bouncy seat set in high places? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid the use of baby walkers? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid putting necklaces or pacifiers on strings around baby's neck? <input checked="" type="checkbox"/> <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage?	If baby is outgrowing the infant carrier car seat (usually at around 20 lbs) switch to a "convertible" car seat. It must remain rear facing until both 1 yr old AND 20 lbs.

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**