



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>HISTORY</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>Y N</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>NUTRITION</p> <p>FORMULA FEEDING:</p> <p>How many ounces in 24 hrs? _____ What formula? _____</p> <p>BREAST FEEDING:</p> <p>How many times does baby nurse in 24 hours? _____</p> <p>How many minutes is each feeding? _____</p> <p>Y N</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 2nd hand smoke.</p> <p>Shaded items are new for the 4 mo check -up.</p> <p>GENERAL FEEDING RECOMMENDATIONS</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>BREAST FEEDING RECOMMENDATIONS</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>STOOLING EXPECTATIONS</p> <p><input type="checkbox"/> BREAST FED: 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"/> FORMULA FED: Stool frequency is variable, but should not be hard balls.</p>

PHYSICAL EXAM	LAB	IMMUNIZATIONS																				
<p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>Check if normal:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> Head/Fontanel</td> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red reflexes</td> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Ears</td> <td><input type="checkbox"/> Throat</td> <td><input type="checkbox"/> Femoral pulses</td> <td><input type="checkbox"/> Extremities</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Genitalia</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p>NOTE EXAM ABNORMALITIES HERE</p>	<input type="checkbox"/> Head/Fontanel	<input type="checkbox"/> Nose	<input type="checkbox"/> Lungs	<input type="checkbox"/> Back	<input type="checkbox"/> Eyes/Red reflexes	<input type="checkbox"/> Mouth	<input type="checkbox"/> Heart	<input type="checkbox"/> Hips	<input type="checkbox"/> Ears	<input type="checkbox"/> Throat	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Extremities		<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin		<input type="checkbox"/> Chest	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Neurologic	<p>_____</p> <p>_____</p> <p>_____</p>	<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>
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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?	
Y N <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?	
M O T O R	Y N <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?
L A N G U A G E Y N <input checked="" type="checkbox"/> <input type="checkbox"/> Do you talk, read and sing to baby?	
S O C I A L	Y N <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.)
	S L E E P How many hours does baby sleep at a time? _____ Y N <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"/>	
Y N <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage and small parts that may cause choking?	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.
<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?	

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!