ABC Pediatrics

Four Month Pre-visit Questionnaire

Patient Name_____ Date_____

Bathes: (Daily) (Every other day)

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Formula: _____Ounces per feeding? _____ Every how many hours? ____

# of stools Daily_____# of voids Daily_____ # of hours sleeping at ONE time_____

Is your child drinking anything else other than breast milk or iron-fortified formula? **YES NO**

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things?_____

Have there been any major changes in your family recently other than your baby's birth?

_____

Developmental Milestones (circle all that apply)

☐ Bears Weight on arms	☐ Reaches for objects	☐ Smiles Spontaneously	☐ Squeals
☐ Laughs	☐ Clasps hands together	☐ Follows objects past midline	☐ Coo's
☐ Rolls front to back	☐ Turns to voice	☐ Blows Bubbles	☐ No head lag
☐ Says ohhh/ahhh	☐ Lifts head 45 degrees		

Any other questions or concerns you would like to discuss?

Weight_____ Temp_____Height_____ Head Circumference_____