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**

Current daycare:________________________________

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___________