4 Month Questionnaire

Patient's Name: ____

Personal/Social History

Are you concerned about your baby's...

1. Excessive spitting, vomiting, or back arching with feedings? .... ☐ Yes ☐ No
2. Bowel Movements: Does your baby have stool that is pale, gray, blood streaked or less than once every 5 days? .... ☐ Yes ☐ No
3. Congestion or wheezing during or after feedings? .... ☐ Yes ☐ No
4. Skin color or rashes (circle one)? .... ☐ Yes ☐ No
5. Crying more than 3 hours a day? .... ☐ Yes ☐ No
6. Overall development? .... ☐ Yes ☐ No
7. Sleep habits? .... ☐ Yes ☐ No

Answer the following:

8. Is your child exposed to tobacco smoke? .... ☐ Yes ☐ No
9. Have you been depressed or crying lately? .... ☐ Yes ☐ No
10. Were there any problems with your child's first set of immunizations? .... ☐ Yes ☐ No
11. Does your baby co-sleep with you? .... ☐ Yes ☐ No
12. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? .... ☐ Yes ☐ No

Does your child...

13. Smile when you approach him/her? .... ☐ Yes ☐ No
14. Coo, babble, laugh, and squeal? .... ☐ Yes ☐ No
15. Turn his/her head toward the direction of sound? .... ☐ Yes ☐ No
16. Move all extremities equally well? .... ☐ Yes ☐ No
17. Roll over (front to back) .... ☐ Yes ☐ No
18. Try to bat at objects? .... ☐ Yes ☐ No
19. Bear weight on both legs? .... ☐ Yes ☐ No

Answer the following:

20. Do you have smoke alarms? ____________ Carbon monoxide detectors? ____________
21. Are you getting enough rest? .... ☐ Yes ☐ No
22. Does your child ride in a rear-facing infant car seat? .... ☐ Yes ☐ No
23. Do you know infant CPR? .... ☐ Yes ☐ No
24. Does your baby sleep with a pacifier? .... ☐ Yes ☐ No
25. Does your baby sleep on his/her back? .... ☐ Yes ☐ No
26. Have both parents/caregivers had the Tdap vaccine? .... ☐ Yes ☐ No
27. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? .... ☐ Yes ☐ No
28. Bottle fed infants: Is your child getting over 30 ounces per day? .... ☐ Yes ☐ No

4 Month Questionnaire

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving a multivitamin with iron? .... ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron? .... ☐ Yes ☐ No
3. Are you having any problems nursing? .... ☐ Yes ☐ No
4. Do you need help from our lactation specialists? .... ☐ Yes ☐ No
5. Do you need help with preparations to return to work? .... ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? .... ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? .... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? .... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? .... ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ...... ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old .... ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months .... ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder .... ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise .... ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant .... ☐ Yes ☐ No

Name and Ages of Brothers ______________________________

Sisters ______________________________

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? .... ☐ Yes ☐ No

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