Health Maintenance Questionnaire

4 MONTHS

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

PARENTS' CONCERNS

List concerns you have?	Please check any body areas that concern you:
1. 2. 3. 4. 5.	☐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

HISTORY

Describe any recent injuries or illnesses:

List medications taken routinely: ☐none

Note any new stresses in the family:

Y N
☐☐Have you gone out without baby?
☐☐Are siblings adjusting to baby OK?

Will Mom return to work/school? ☐No ☐at _____ wks old ☐is back to work/school

Will baby go to day care? ☐No ☐Yes ☐Nanny ☐In day care now.

How many kids in the room/home? ______

Are there smokers in your baby's home or day care? ☐No ☐outside ☐other room

- Avoid 2nd hand smoke.

NUTRITION

FORMULA FEEDING:

How many ounces in 24 hrs? ______ What formula? ______

BREAST FEEDING:

How many months do you plan to breastfeed? ______

Mom's medications: ☐prenatal vitamin Other:

IN THE PAST 24 HOURS:

Is baby nursed on demand? ☐yes ☐no

Latched _____ times Average minutes each time:_____

Pumped _____ times Total ounces: _____

Fed _____ ounces of pumped milk Fed _____ ounces of formula– type:_____

GENERAL FEEDING RECOMMENDATIONS

- Formula with iron until age 1.
- Introduce solids between 4-6 months old.
- Start with #1 baby food jars.

BREAST FEEDING RECOMMENDATIONS

- 8-12 feedings in 24hrs is typical
- Nurse at least every 3 hours during the day so baby will sleep longer at night.
- Should sleep more at night, but expect at least one night feeding.
- Don't go more than 5hrs at night without removing milk (pump if baby sleeps longer)
- If baby is supplemented with pumped breast milk or formula → pump (supply : demand)
- Should follow the growth curve at check-ups.
- Request a weight check if baby is excessively sleepy, fussy, or not clearly gaining weight.
- Needs at least 24oz of milk each day
- Feed on demand
- Back to work? Pump/freeze milk properly.
- Delay solids until 6 months old.
- Mom should not diet. Drink to thirst.
- Vitamins as prescribed by the doctor.

How many of each per day: spit ups: ______ wets: ______
How often does baby pass stool? ______

STOOLING EXPECTATIONS

BREAST FED: Stools several times per day or only once per week. This is normal if it is soft. Stools will change if formula is used.
FORMULA FED: Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM	Lab/Immunizations
Ht_______ Wt________ HC_______ VS:________________________ EXAM:	

ASSESSMENT	PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name: Birth Date:

4 month

DEVELOPMENT AND BEHAVIOR

☐Yes ☐No Are you concerned about your child's development or behavior?

Y N
☐☐Does baby turn his/her head toward your voice?
☐☐Does s/he follow your face or an object with his/her eyes through 180 degrees?

MOTOR

Y N
☐☐Does baby hold her head straight when pulled from lying to sitting?
☐☐Does baby push his/her chest off the floor and hold the head high?
☐☐Is s/he trying to roll over?
☐☐Will baby open his/her hands when at rest?
☐☐Does s/he reach for and bat at objects or the mobile?

SOCIAL

Y N
☐☐Does baby initiate social contact by smiling, cooing, laughing, squealing?
☐☐Is your baby starting to experience "stranger anxiety?"
☐☐Is s/he starting to enjoy peek-a-boo, so-big and pat-a-cake games?
☐☐Does baby seem to be "teething?" (Teeth usually appear after 6 months.)

LANGUAGE

Y N
☐☐Do you talk, read and sing to baby?

SLEEP

How many hours does baby sleep at a time?

Y N
☐☐Have you established a bedtime routine?
☐☐Can baby comfort self and fall asleep without feeding?
☐☐Do you put him/her down when drowsy to teach self-quieting?
☐☐Does baby suck his/her thumb? (This is usually established by now if it will be a habit.)
☐☐Do you put baby down on his/her back?
☐☐Do you avoid bulky bedding in the crib?
☐☐Do you try to avoid falling asleep with baby in your bed or while resting on a couch/soft chair?

Where does baby sleep?

SAFETY AWARENESS

The shaded items are new for the 4 month visit.

Y N
☐☐Do you check toys for breakage and small parts that may cause choking?
☐☐Is baby's car seat rear facing in the back seat?➔
☐☐Is the water temperature in your house less than 120 degrees?
☐☐Do you avoid drinking hot liquids while holding your baby?
☐☐Do you limit sun exposure?
☐☐Do you have a fire escape plan?
☐☐Do you check your smoke detectors regularly?
☐☐Do you monitor baby closely around young siblings or pets?
☐☐Do you avoid putting baby in the car seat / bouncy seat set in high places?
☐☐Do you avoid the use of baby walkers?
☐☐Do you avoid putting necklaces or pacifiers on strings around baby's neck?
☐☐Are you aware that shaking your baby could cause permanent brain damage?

2019 Nebraska Car Seat Law:
Kids ride rear-facing until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer.
Kids under 8 must ride in the back seat.

POSTPARTUM DEPRESSION SCREENING

☐**Yes** ☐**No** **Are you concerned about your mood or feeling depressed?**

In the past 7 days:

1. I've been able to laugh and see the funny side of things. 0 As much as I used to. 1 Not quite so much now. 2 Definitely not so much now. 3 Not at all.	6. Things have been getting on top of me. 3 Yes, most of the time I haven't been able to cope at all. 2 Yes, sometimes I haven't been coping as well as usual. 1 No, most of the time I have coped quite well. 0 No, I've been coping as well as ever.
2. I've looked forward with enjoyment to things. 0 As much as I ever did. 1 Rather less than I used to. 2 Definitely less than I used to. 3 Hardly at all.	7. I've been so unhappy that I've had difficulty sleeping. 3 Yes, most of the time. 2 Yes, sometimes. 1 Not very often. 0 No, not at all.
3. I've blamed myself unnecessarily when things went wrong. 3 Yes, most of the time. 2 Yes, some of the time. 1 Not very often. 0 No, never.	8. I've felt sad or miserable. 3 Yes, most of the time. 2 Yes, quite often. 1 Not very often. 0 No, not at all.
4. I've been anxious or worried for no good reason. 0 No, not at all. 1 Hardly ever. 2 Yes, sometimes. 3 Yes, very often.	9. I've been so unhappy that I've been crying. 3 Yes, most of the time. 2 Yes, quite often. 1 Only occasionally. 0 No, never.
5. I've felt scared or panicky for no very good reason. 3 Yes, quite a lot. 2 Yes, sometimes 1 No, Not much. 0 No, Not at all.	10. The thought of harming myself has occurred to me. 3 Yes, quite often. 2 Sometimes. 1 Hardly ever. 0 Never.

I have a mental health therapist: Yes No
I am currently taking medication for anxiety / depression / mental health. No Yes: drug name:

Who answered the above questions?

Thank you for helping us help you and your child!!