Name: _____ Date of birth: _____

Health Status Questionnaire – 4 Months

Baby lives with: mother father both parents other:_____

Childcare: daycare babysitter stays at home other:_____

Breastfeeding? Y N Every ____ hours For _____ minutes per side

Formula feeding? Y N Formula: _____

____ oz every ____ hours, _____ oz total 24 hours

If at least ½ the feedings are breastmilk, giving vitamin D supplement? Y N

Any problems feeding? Y N _____

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Lift his/her head and chest when laying on tummy?	Y	N
Roll over at least one way?	Y	N
Control his/her head when in sitting position?	Y	N
Attempt to grasp objects with hands?	Y	N
Bring hands together?	Y	N
Move both eyes completely from one side to the other?	Y	N
Smile, laugh, squeal and coo?	Y	N
Seek eye contact?	Y	N
Turns to noise?	Y	N

Passive smoke exposure: Y N Car seat use: Y N

Smoke detectors: Y N Fire extinguishers: Y N

Do you have any concerns about your baby? _____

_____