Pediatric Health Maintenance: 4 Months
Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health ☐ I'd like to discuss		
☐ Yes	☐ No	Is your child in daycare or the care of a babysitter?

Feeding and Sleeping ☐ I'd like to discuss		
What is your baby fed? ☐ Breastmilk ☐ Formula (type):		
Ounces per feeding (if bottle fed):		
My baby feeds every _____ hours during daytime and is usually up _____ times during the night to feed.		
Any vitamins?	☐ Vitamin D ☐ Iron ☐ Other:	
Where does your baby sleep? ☐ Crib/bassinet ☐ Parent's bed ☐ Other		
☐ Yes	☐ No	Does your baby sleep on his or her back?
☐ Yes	☐ No	Do you think your baby's bowel movements are normal?

Development ☐ I'd like to discuss		
☐ Yes	☐ No	Does your baby grasp a toy, and put his or her hand to their mouth?
☐ Yes	☐ No	Does your baby calm when he or she hears your voice?
☐ Yes	☐ No	Does your baby laugh and squeal?
☐ Yes	☐ No	Does your baby respond to noise?
☐ Yes	☐ No	When you hold your baby in a sitting position, does your baby hold his or her head steady?
☐ Yes	☐ No	When you move a toy from side to side in front of your baby's face, does he or she follow the toy with their eyes?

Safety ☐ I'd like to discuss		
☐ Yes	☐ No	Does your home have functioning smoke detectors?
☐ Yes	☐ No	Does your child ride in a rear-facing car seat, in the back seat?
☐ Yes	☐ No	Do you leave your baby alone on the changing table, sofa, or bed?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 4 Months form.

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME & ID #

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