OBERLIN ROAD PEDIATRICS

Well Child Check: 4 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? If yes, please list. □ No □ Yes: _____

Does your child have known allergies to foods/medicines? If yes, please list.

□ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Nutrition:

Does your baby drink breastmilk, iron fortified formula, or both? □ Breastmilk □ Formula □ Both

If you are giving your baby bottles, how many ounces does your child take in 24 hours? _____

Development: Does your child……

Smile to get your attention?	Yes	No
Chuckle or laugh when you try to make him laugh?	Yes	No
Look at you, move, or make sounds to get or keep your attention?	Yes	No
Make sounds like Ooooh? Aaaaah? (cooing)	Yes	No
Make sounds back when you talk to him?	Yes	No
Turn her head to the sound of your voice?	Yes	No
Look at his hands with interest?	Yes	No
Hold her head steady without support when you are holding her?	Yes	No
Hold a toy when you put it in his hand?	Yes	No
Use her arm to swing at toys?	Yes	No
Bring hands to his mouth?	Yes	No
Push up onto elbow/forearms when on her tummy?	Yes	No

Social Update:

Who lives at home with your child? _____

Are parents: single married divorced separated widowed

Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life?

□ No □ Yes_____

Do you always place your infant to sleep on their back?	Yes	No
Does the baby always sleep in a crib or bassinet?	Yes	No
Are you satisfied with your baby's sleep?	Yes	No
Do you have working smoke alarms in your home?	Yes	No
Does anyone smoke or vape in your home?	No	Yes
Do you have a daily routine for feeding, naps, and bedtime?	Yes	No
Is a TV, computer, or tablet on in the background when your baby is in the room?	No	Yes
Does your baby play on a tablet or smartphone or watch TV?	No	Yes
Do you put your baby on her tummy for short periods of time when she is awake?	Yes	No
Do you have ways to calm your baby when he is crying?	Yes	No
Do you and your baby enjoy quiet activities such as reading, singing, or taking walks outside?	Yes	No
Have you gone back to work?	Yes	No
If yes, are you happy with your child's caregiver?	Yes	No
Is your baby fastened securely in a rear facing care seat in the back seat every time they ride in the car?	Yes	No
Is your water heater set so the temperature is at or below 120 degrees F?	Yes	No
Do you always stay within arm's reach of you baby when on the changer, bed or in/near water?	Yes	No
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never