



## 4 Month Health Maintenance Questionnaire

Patient Name \_\_\_\_\_

Who accompanied child today?  
(name and relationship to child)

\_\_\_\_\_  
\_\_\_\_\_

Who does child live with?

\_\_\_\_\_  
\_\_\_\_\_

Any Chronic health problems?

\_\_\_\_\_  
\_\_\_\_\_

Concerns about the above health problems?

\_\_\_\_\_  
\_\_\_\_\_

New or recent health concerns?

\_\_\_\_\_  
\_\_\_\_\_

**Feedings:**

**Breastfeeding:**

How many times per day do you breastfeed?

\_\_\_\_\_

**Bottle Feeding:**

How many ounces per day?

\_\_\_\_\_

Brand of Formula used?

\_\_\_\_\_

Any juices or solids started?

\_\_\_\_\_

If yes, what type?

\_\_\_\_\_

Any concerns with stooling or urination?

\_\_\_\_\_

*If you do not understand any of these questions, please ask your nurse.*

**Sleep pattern:**

Average number hours of sleep in 24 hours: \_\_\_\_\_

Frequency of nighttime awakenings: \_\_\_\_\_

Number of naps: \_\_\_\_\_

Length of naps: \_\_\_\_\_

Where does your child sleep? \_\_\_\_\_

Are there any smokers in the household? \_\_\_\_\_

Please list current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any allergies to medicine? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does your baby:**

Hold head up 90 degrees when on tummy? Yes No

(can look straight ahead while on tummy?)

Lifts chest off the floor using forearms? Yes No

Have steady head control when upright? Yes No

Roll over from Front to Back? Yes No

Open hands to hold objects, play with hands? Yes No

Follow you with his/her eyes 180 degrees? Yes No

Vocalize, coo, squeal or laugh? Yes No

Smile spontaneously? Yes No

Initiate social interaction with you? Yes No

*If you do not understand any of these questions, please ask your nurse.*