Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

# 4 Month Old Parent Observations

Are there any concerns you would like to discuss today?_____

_____

## Feedings:

Any concerns about feedings or weight gain? Yes No

If breastfeeding, are you giving Vitamin D drops daily? Yes No

If bottle feeding: ☐ Pumped Breastmilk ☐ Formula (Name:_____)

Baby foods: ☐ Not Started ☐ Cereals ☐ Fruits ☐ Vegetables

## Voiding/Stooling:

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) Yes No

Quality of stools: ☐ Liquidy/Seedy ☐ Soft/Formed ☐ Hard pellets/Logs

## Sleep:

Any concerns about sleep? Yes No

Is your child sleeping on his/her back? Yes No

How many uninterrupted hours of sleep at night (i.e. in between feeds)? _____

How many naps per day? _____ How long is each nap? _____

Is your child sleeping in a: (please choose one) Bassinet Crib Co-Sleeping

## Development:

Are you doing tummy time daily with your child? Yes No

Are you reading to your child? Yes No

Does your child ever cross his/her eyes? Yes No

Do you have any concerns about your child's hearing or vision? Yes No

Does your child: (please check all that apply)

☐ lift his/her head 90° above surface ☐ push chest up with arms when lying on belly

☐ have good head control ☐ babble and coo

☐ follow with eyes 180° ☐ smile/laugh

☐ grab for objects ☐ roll over (belly to back OR back to belly)

## Social:

If parents work, who cares for your child? _____

Are family members and siblings (if any) doing well with the baby? Yes No

## Safety/Preventative Health:

Does your baby use a rear-facing care seat 100% of the time? Yes No

Is your home/car a smoke-free environment? Yes No

Any recent illnesses or fevers in last 24 hours? Yes No

Any questions or concerns about immunizations? Yes No

Please list any medications or supplements your child took this week: _____

_____