4 Month Pre-Visit Questionnaire

***Instructions*:** Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health		
1. Do you have any concerns about your baby?	NO	YES
2. Crying longer than 30 minutes at a time?	NO	YES
3. Skin color or skin rash concerns?	NO	YES
4. Severe nasal congestion?	NO	YES
5. Wheezing?	NO	YES
6. Any problems with previous immunizations?	NO	YES
Feeding/Nutrition		
7. Is your child breastfeeding well?	YES	NO
a. How often?		
b. For how long? (minutes)		
8. Is your child taking formula well?	YES	NO
a. How often?		
b. How many ounces?		
c. Which formula?		
9. Are you giving baby any solid foods?	NO	YES
10. Are you giving any vitamins or supplements?	NO	YES
Oral Health		
11. Do parents regularly see a dentist, brush and floss teeth?	YES	NO
12. Do you put your baby to bed with a bottle?	NO	YES
Elimination		
13. Problems with bowel movements (pooping)?	NO	YES
14. Concerns about urination (peeing)?	NO	YES
Sleep		
15. Sleeps five or more hours at a time?	YES	NO
16. Do you put baby in the crib when drowsy, not fully asleep?	YES	NO
17. Questions about sleep habits?	NO	YES
18. Does your baby wake at night to eat?	NO	YES
Social Stressors		
19. If there are other children at home, have they adjusted well to your baby?	YES	NO
20. Are you able to take a little time for yourself?	YES	NO
21. Has mother been sad or crying a lot? Feeling down, depressed, or hopeless?	NO	YES
22. Are you having family stress?	NO	YES
23. Do you ever worry your family will go hungry?	NO	YES
24. Do you have daycare concerns?	NO	YES

Development

25. Baby smiles when approached?	YES	NO
26. Coos, babbles, laughs?	YES	NO
27. Has different cries to indicate hunger, tiredness, pain?	YES	NO
28. Moves all extremities well?	YES	NO
29. Tries to reach for objects?	YES	NO
30. Rolling?	YES	NO
31. Lifts upper body on elbows?	YES	NO
32. Lifts head well when lying on tummy?	YES	NO
33. Has good head control?	YES	NO
34. Do you hold, cuddle, talk, and play with your baby?	YES	NO

Safety

35. Infant sleeps on the back?	YES	NO
36. Infant sleeps in a bassinet or crib, not in parents' bed?	YES	NO
37. Do you always keep a hand on your baby when placed above the floor?	YES	NO
38. Does baby wear any jewelry (including necklaces)?	NO	YES
39. Is your infant exposed to anyone who smokes?	NO	YES
40. Does your home have working smoke detectors and carbon monoxide detectors?	YES	NO
41. Do you hold or carry hot liquids around the baby?	NO	YES
42. Do you keep plastic bags and latex balloons away from baby?	YES	NO
43. Infant rides in a rear-facing safety seat, in the back seat?	YES	NO
44. Are you using shading or sunscreen if your baby is in the sun more than 10 minutes?	YES	NO

Tuberculosis

45. Has a family member or contact had tuberculosis disease?	NO	YES
46. Has a family member had a positive TB skin test (PPD)?	NO	YES
47. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
48. Has your child traveled to a high-risk country for more than a week?	NO	YES