**4 Month Well Baby Questionnaire**



*Office Use Only*

VFC: [ ] V02 -- MDD

[ ] V03 – No Ins

[ ] V04 -- Native

[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

*Office Use Only*WT: \_\_\_\_\_\_\_kg \_\_\_\_\_\_\_lb

TEMP:\_\_\_\_\_\_\_ OFC:\_\_\_\_\_\_

Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TECH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note that "well child visits"** are a form of preventative medicine, meant to catch any potential problems in a child’s physical or developmental health. Each exam is tailored to the child’s age, and may include necessary immunizations, vision, hearing, and developmental screenings. If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any concerns about your baby today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby on any medicine? Yes / No. Which ones/dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies to medicine, latex, etc? Yes / No. Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your baby had any difficulty with past immunizations? Yes / No. If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your baby had any surgeries? Yes / No. If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been hospitalized overnight? Yes / No. Is yes, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health**Is your baby exhibiting any of the following symptoms?

Ear Pain / Ear Pulling Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fever Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Drainage Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Swelling Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Drainage Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cough Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Decreased Appetite Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Vomiting Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Constipation / Gas Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Diarrhea Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary Symptoms Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Rash Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Problems Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Joint Pain Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**

|  |  |
| --- | --- |
| **Breast Feeding Yes / No** | **Formula Feeding Yes / No** |
| How often & how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is mom on any medication or vitamin supplements? Yes / No.  Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Which formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many ounces & how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Is your baby on vitamins? Yes / No. If yes, which brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle your baby’s water supply source: City Bottled Well.

Is your baby on solid foods? Yes / No. If yes, circle: Cereal | Fruits | Vegetables.

Is your child teething? Yes / No. If yes, how many teeth have erupted? \_\_\_\_\_\_\_\_\_

**Social**Any changes in your baby’s environment? (new home, pets, daycare, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the household with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary caretaker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does anyone in the family smoke? Yes / No. If yes, who?\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Mom working? Yes / No. Full time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Dad working? Yes / No. Full time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby in daycare? Yes / No. If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? Yes / No. If yes, which kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any food allergies in your family? Yes / No. If yes, who and to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep and Elimination**

How many hours does your baby sleep straight at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many naps does your baby take each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many wet diapers per day? \_\_\_\_\_\_\_\_ How many stools? \_\_\_\_\_\_\_\_ Does your baby have a good urine stream? Yes / No.

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**