



PATIENT NAME: _____

Questions for 4 Month Visit

DATE: ____ / ____ / ____

Please complete the following questions as they apply to your infant.

NUTRITION

Breastfeeding

Are you breast feeding? yes no

Do you feel that breast feeding is going well? yes no

If no, please explain: _____

Regarding breast feeding, are you?

exclusively breast feeding exclusively pumping breast feeding and pumping breast feeding and supplementing with formula

Approximately how long does your infant feed from each breast?

< 10 minute > 10 minutes

Approximately how often does your infant feed?

every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

<5 5 to 6 7 to 8 > 8

Have you introduced an occasional bottle? yes no

Do you currently plan on returning to work while breast feeding or pumping? yes no

Are you interested in information regarding breast feeding or pumping at work? yes no

Are you currently taking your prenatal vitamins? yes no

Formula

Regarding formula, is your infant?

completely formula fed supplemented with formula after breast feeding not formula fed

How many ounces does your infant take per feeding?

1 to 2 oz 2 to 4 oz 4 to 6 oz 6 to 8 oz

Approximately how often does your infant feed?

receives formula as a supplement after each breast feeding receives formula randomly as a supplement to breast feeding

every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

<5 5 to 6 7 to 8 > 8

What type of formula do you feed your infant?

Enfamil Lipil Similac Advance Nestle Goodstart Isomil Prosobee Nutramigen

Enfacare Neosure Other: _____

Solids

Has your infant started solid (complementary) foods? yes no

If yes, what type?

iron fortified cereal stage 1 products stage 2 products home-made baby foods

ELIMINATION

How many wet diapers does your infant have per day?

> 6 < 6

How frequent does your infant have a bowel movement?

> 6 per day 3 to 6 per day 1 to 2 per day 1 per day
 every other day every 3 to 4 days > every 4 days

Is your infant having any problems with his/her bowel movements? yes no

If yes, please explain: _____

SLEEP

How long does your infant sleep (consecutively) at night?

2 to 3 hours 3 to 4 hours 4 to 6 hours > 6 hours

How many naps does your infant take during the day?

none 1 2 3 >3

Is your infant sleeping on his/her back? yes no

Is your infant using a pacifier to fall asleep? yes no

Are you establishing a bedtime ritual? yes no

Are you placing your infant to sleep partially or fully awake? yes no

Where is your infant sleeping?

in a bed with his/her caregiver(s) in a bassinet in his/her caregiver(s) room in a crib in his/her caregiver(s) room
 in a crib in a separate room from his/her caregiver(s) Other: _____

VISION

Do you have any concerns regarding your infant's vision? yes no

If yes, please explain: _____

HEARING

Do you have any concerns regarding your infant's hearing? yes no

If yes, please explain: _____

DEVELOPMENT

Babbles and coos	<input type="checkbox"/> yes	<input type="checkbox"/> no
Smiles, laughs, and squeals	<input type="checkbox"/> yes	<input type="checkbox"/> no
When lying on stomach, holds head upright and raises body on hands	<input type="checkbox"/> yes	<input type="checkbox"/> no
Rolls over from front to back	<input type="checkbox"/> yes	<input type="checkbox"/> no
Opens hands, holds own hands, grasps rattle	<input type="checkbox"/> yes	<input type="checkbox"/> no
Controls head well	<input type="checkbox"/> yes	<input type="checkbox"/> no
Begins to bat at objects	<input type="checkbox"/> yes	<input type="checkbox"/> no
Looks at and may become excited by mobile	<input type="checkbox"/> yes	<input type="checkbox"/> no
Follows objects with his/her eyes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Recognizes your voice and touch	<input type="checkbox"/> yes	<input type="checkbox"/> no
Turns head to sound	<input type="checkbox"/> yes	<input type="checkbox"/> no
Has spontaneous social smile	<input type="checkbox"/> yes	<input type="checkbox"/> no

SAFETY

What type of car seat does your infant use?

a 5 point (rear facing) infant carrier in the back seat of the vehicle other:

J.A.N. 27.2010 Signature of Provider _____ Date: _____ / _____ / _____