MUNDELEIN PEDIATRICS

4 Month Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Breastfeeding: Yes/No Concerns: _____
2. Formula feeding: Yes/No Concerns: _____
3. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
   (____) hours from naps during the day

4. Excessive spitting or vomiting: Yes/No Concerns: _____
5. Urinating well: Yes/No Concerns: _____
6. Normal bowel movements: Yes/No Concerns: _____
7. Sleeps on back: Yes/No Concerns: _____
8. Rides in a rear-facing car seat in the back seat: Yes/No
9. Takes vitamins: Yes/No Product name: _____
10. Emergency room visits: Yes/No
11. Illness since last visit: _____
12. Developmentally: smiles responsively, coos/laughs/squeals/babbles, sitting with support-holds head erect, likes tummy time, holds head up while on belly, rolls over (front to back), reaches and grasps objects, when head erect pushes with feet.

Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Daycare: None/Relative/Center/Babysitter
4. Primary care taker: Mom/Dad/Grandparents
5. Household composition:
   Adult(Names/Ages): _____

   Children(Names/Ages): _____

6. New health problems in parents or siblings: _____
7. Past vaccine reactions: Yes/No
8. Sibling rivalry: Yes/No
9. Post-partum depression in mom (crying a lot, sad, depressed): Yes/No

Do you have any other concerns you wish to discuss? Yes/No

_____

_____

_____