Sutter Health
With You. For Life.

Your Child's Name: _____

4 Month Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you.

Does your child lift her head when on the tummy?	Yes	No	Unsure
Does your child roll over?	Yes	No	Unsure
Can your child hold the head steady as you pick him/her up?	Yes	No	Unsure
Does your child reach for objects?	Yes	No	Unsure
Does your child hold object briefly?	Yes	No	Unsure
Does your child babble (make "ba", "ga", "ma" sounds)?	Yes	No	Unsure
Does your child smile?	Yes	No	Unsure
Does your child laugh or squeal?	Yes	No	Unsure

Does your baby drink breastmilk or formula? Breastmilk Formula Both

If you are giving formula, how many ounces does your child take in 24 hours? _____oz

Type of formula?_____

Do you have a regular bedtime routine for your child?	Yes	No	Unsure
Was your child born within 3 weeks of his or her due date?	Yes	No	Unsure
Did your child weigh more than 5 pounds 8 ounces (2500gm) at birth?	Yes	No	Unsure

Is there a family history of hay fever, asthma, eczema or food allergies?	Yes	No	Unsure
If yes, please explain:			
Has mom been feeling sad, anxious, hopeless or depressed often?	Yes	No	Unsure

Who provides daytime care for your child? _____

Is your child on any medications or supplements, including vitamins? If so, please list below:

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?