Well Child Check:
4 Month Visit

marinhealth Medical Network | UCSF Health

Childs Name: _____ DOB: _____ Date: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues.

Can your child lift his/her head when on tummy?	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 objects briefly?	YES	NO	UNSURE
Does your child smile?	YES	NO	UNSURE
Does your child coo (make “ooh” or “ahh”) sounds?	YES	NO	UNSURE
Does your child laugh or squeal?	YES	NO	UNSURE
Do you have a regular bedtime for your child?	YES	NO	UNSURE
Was your child born after the 37th week of pregnancy?	YES	NO	UNSURE
Does your child weigh more than 5lbs 8 ounces (2500gm) at birth?	YES	NO	UNSURE
Does your baby drink: **Breast Milk Formula Unsure**			
If you are giving formula, how many ounces does your child take in 24 hours? _____ oz. Type of formula?			
Is your child on any medications or supplements including vitamins? If so, please list below:			
Who provides daytime care for your child?			
Has mom been feeling sad, anxious, hopeless or depressed?	YES	NO	UNSURE
Has mom felt very little or no interest or pleasure doing things?	YES	NO	UNSURE

Do you have any other concerns about your child’s development or any other concerns you would like to discuss with the provider? If YES, please describe below: