

4 MONTH WELL CHILD VISIT

Hirsch Holistic Family Medicine

3525 Ensign Rd NE Ste N

Olympia WA 98506

(360) 464-9965 / (800) 897-8320 fax

Patient name: _____ Date _____ Age _____

Accompanied by: _____ Birthdate _____

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

Yes No Overall, I feel confident that my baby is doing well
Yes No I have enough help with the baby
Who lives with you and the baby? _____

Who cares for your baby during the day? _____
How would you describe your baby's personality? _____

No Yes I am having some "baby blues"

FEEDING/SLEEPING

No Yes I have questions about my baby's feeding
My baby takes breast milk every _____ hrs, or
_____ Formula, _____ oz, every _____ hrs
What solid food has your baby tried? _____
Yes No I am satisfied with my baby's sleep schedule
Longest sleep period: Daytime _____ Nighttime _____
How do you get your baby to sleep?
Feeding / Rocking / Pacifier / Self / Other
Where does your baby sleep? _____

VOIDING AND STOOLING

No Yes My baby pees and poops normally
Wet diapers _____ Stool diapers _____ per day

DEVELOPMENT

No Yes I have questions about my baby's development _____

Yes No My baby recognizes my voice
Yes No My baby looks from one side to the other
Yes No My baby laughs and squeals
Yes No My baby holds his/her head steady
Yes No My baby reaches for and grabs objects
Yes No My baby puts his/her hands together

PREVENTION

No Yes My baby lives with someone who smokes cigarettes
Yes No I always keep my baby in the car seat when driving
Yes No My baby sleeps only on his/her side or back
Yes No I know how to take a temperature and treat a minor cold
No Yes I have questions about immunizations/shots
Yes No I have smoke detectors at home
Yes No My hot water heater is set to 120°F
Yes No My house is "child-proofed"
No Yes Are there any other issues you want to discuss today?

DISCUSSION TOPICS

General questions

Parenting Support
Partner, sibling adjustment

Postpartum depression

Continue breastfeeding
Solids optional
Iron source by 6 months
Vit D supplement if
formula < 500cc per day
Normal range 2-8 hours
Avoid bedtime bottle
Avoid bottle propping
Safe sleep environment
Sleep associations
Nighttime crying

Normal variation

R-PDQ if concerns
Separation anxiety
Anticipate rolling/falls
Tummy time

Risk of tobacco exposure
Smoking cessation
No exceptions with car seat
SIDS prevention
Teething, cleaning teeth
Everything to the mouth
Smoke detector maintenance
Burn prevention, crib safety
Injuries #1 cause of death

