4 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1 Do you have concerns about your baby?	NO	YES
2 Does your baby cry for longer than 30 minutes at a time?	NO	YES
3 Do you have any concerns about skin color or rashes?	NO	YES
4 Does your baby make a wheezing or whistling sound when breathing or have any trouble breathing?	NO	YES
5 Has your baby had any problems with shots or immunization	NO	YES

Feeding/Nutrition

6 Is your baby breastfeeding?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a How many times a day does your baby breastfeed?			
7 Is your baby taking (drinking) formula?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a How many times a day does your baby take/drink formula?			
c Which formula are you feeding your baby?			
8 Are you giving your baby any solid foods?	NO	YES	
9 Do you give your baby any vitamins or supplements?	YES	NO	

Oral Health

10 Do the PARENTS regularly see a dentist, brush and floss teeth and gums?	YES	NO
11 Do you put your baby to bed with a bottle?	NO	YES

Elimination

12 Does your baby have any problems with bowel movements (going poop)?	NO	YES
13 Urinating (peeing) well?	YES	NO

Sleep

14 Do you put baby in the crib when drowsy, not fully asleep?	YES	NO
15 Do you have any questions or concerns about your baby's sleep habits?	NO	YES
16 Does your baby wake at night to eat?	NO	YES

Social Stressors

17 Has either parent been feeling down, depressed, or hopeless?	NO	YES	
18 Has either parent had little interest or pleasure in doing things they used to enjoy?	NO	YES	
19 If there are other children in the house, are they adjusting well to your baby?	YES	NO	N/A
20 Do you feel that you receive the support you need?	YES	NO	
21 Are you having any family stress?	NO	YES	
22 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
23 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
24 Do you have any worries or concerns about childcare?	NO	YES	
25 Do you Ever feel angry or frustrated with your baby?	NO	YES	

Development
(If you are completing the Ages and Stages questionnaire please skip this section)

26 Does your baby smile when approached?	YES	NO
27 Does your baby coo, babble, and laugh?	YES	NO
28 Does your baby have different cries to let you know when he/she is hungry, tired, or in pain?	YES	NO
29 Does your baby move all arms and legs well?	YES	NO
30 Does your baby try to reach for objects?	YES	NO
31 Does your baby roll around?	YES	NO
32 Does your baby lift his/her upper body on elbows?	YES	NO
33 Does your baby lift his/her head well when lying on tummy?	YES	NO
34 Does your baby have good head control?	YES	NO
35 Do you hold, cuddle, talk, and play with your baby?	YES	NO

Safety

36 Does your baby sleep on his/her back?	YES	NO
37 Where does your baby sleep?	Crib/Bassinet	Parents' bed
38 Do you always keep a hand on your baby when placed above the floor? (like on a changing table)	YES	NO
39 Does your baby wear any jewelry (including necklaces)?	NO	YES
40 Do you hold or carry hot liquids around the baby?	NO	YES
41 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
42 Does anyone smoke or vape around your baby?	NO	YES
43 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
44 Are you using a shade or sunscreen if your baby is in the sun more than 10 minutes?	YES	NO

Tuberculosis

Question		
45 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
46 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
47 Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe?	NO	YES
48 Has your baby traveled to a high-risk country for more than a week?	NO	YES