4 MONTH WELL CHECK-UP

NAME_____**DATE**_____**DOB**_____

Caregiver concerns: _____

_____

Daily Activities
Sleep (hours/day)_____
Sleep (hours/night)_____
Activities when awake_____

Feeding
Formula or breast_____
How much_____
How often _____
Total amount/day (should never exceed 32oz)_____
Other foods_____
Juices_____

Stools
Number_____
Color_____
Consistency_____
Constipation_____

Development
Laughs out loud_____
Head control_____
Hand in mouth_____
Reaches for objects_____
Pulls up (early)_____
Rolls front to back_____

Physical Exam
Please use growth chart
Hgt_____ % _____
Wgt_____ % _____
H.C._____ % _____
HEENT_____

_____

Neck_____
Lungs_____
Heart_____
Abdomen_____

GU_____
Ortho_____
Neuro_____
Skin_____

Impression

_____

_____

Plan DTaP/OPV/IPV/HIB HBV (2-4 months)

_____

Topics Discussed
1. Keep harmful objects out of reach_____
2. Prevent rolling off flat surface_____
3. Size and sharpness of toys (baby puts everything into mouth and ears)_____
4. Appropriate dose of Tylenol for temperature > 101 degrees that is related to DTaP immunization_____
5. Poison Control Number_____
6. Other_____

Return to office_____