IMPRINT AREA

4 Month Health Questionnaire

KAISER PERMANENTE®

This information is confidential.

Your answers help your physician or nurse practitioner choose the best topics to discuss with you at this visit. Skip any questions you don't understand or do not apply.

Phone:

What Do You Enjoy About Your Baby? Do You Have Any Questions or Concerns?

#	Question		
1.	Do you feed your baby breastmilk?	❒ No	❒ Yes
2.	Do you feed your baby infant formula with iron?	❒ No	❒ Yes
3.	Does your baby eat infant cereal, baby, or strained foods?	❒ No	❒ Yes
4.	Do you always place your baby in a car seat facing backwards, in the back seat?	❒ No	❒ Yes
5.	Do you always place your baby on his or her back to sleep?	❒ No	❒ Yes
6.	Do you ever drink hot liquids when holding your baby?	❒ Yes	❒ No
7.	Do you know what to do if your baby is choking?	❒ No	❒ Yes
8.	Do you ever leave your baby alone on a changing table or bed?	❒ Yes	❒ No
9.	Do you have a plan for escape from the house in the event of an earthquake or fire?	❒ No	❒ Yes
10.	Does your baby spend time in a home where anyone smokes?	❒ Yes	❒ No
11.	Since your last well check, have there been any MAJOR illnesses, hospitalizations, surgeries, changes, or stresses for your family or baby? If yes, please list:	❒ Yes	❒ No
12.	Please list any medications your baby is taking:		
13.	Does your baby have any allergies to medications? If yes, please list:	❒ Yes	❒ No
14.	Do you often feel sad, depressed, or blue?	❒ Yes	❒ No
15.	Do you put your baby to sleep when he or she is drowsy but still awake?	❒ No	❒ Yes
16.	Do you use a hat or umbrella to protect your baby from the sun if he or she is outside for more than 10 minutes?	❒ No	❒ Yes
17.	Does your baby laugh out loud and squeal?	❒ No	❒ Yes
18.	Does your baby push up with arms when on his or her stomach?	❒ No	❒ Yes
19.	Does your baby look at you when you talk to him or her?	❒ No	❒ Yes
20.	Does your baby reach and grab for objects?	❒ No	❒ Yes
21.	Do you have concerns about your baby's development or behavior?	❒ Yes	❒ No
22.	Does your baby sleep through the night?	❒ No	❒ Yes
23.	Do you cuddle and talk to your baby every day?	❒ No	❒ Yes
24.	Is your baby in day care? Who else takes care of your baby?	❒ Yes	❒ No
25.	Has your baby ever had a reaction to a vaccine (such as a high fever)?	❒ Yes	❒ No

Clinic Counseling

❒ Questionnaire Reviewed

❒ Pertinent Topics Discussed and Advice Given

Sign: ______________

Parent Signature: ______________________________ Date: ______

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