PEDIATRIC HEALTH
ASSESSMENT HEALTH
4 MONTHS

CHILD'S NAME:_____ DATE:_____

AGE:_____ DATE OF BIRTH:_____

CURRENT MEDICATIONS_____

PRESENT CONCERNS/PROBLEMS_____

_____

ACCOMPANIED BY:_____ RELATIONSHIP:_____

DAILY LIVING: (FILLED OUT BY PARENT OR GUARDIAN)

DIET: OUNCES PER DAY OF FORMULA_____ (TYPE OF FORMULA)_____ (No. FEEDS/DAY)_____
BREAST FEEDING: TOTAL MINUTES PER FEEDING_____ NUMBER OF FEEDS PER DAY_____
BABYFOOD: circle JAR or FRESH (Check off) CEREAL _____ FRUIT _____VEGS _____
JUICE (OUNCES/DAY)_____ WATER (OUNCES/DAY) _____

VITAMINS /IRON ……	☐ NO	☐ YES
ANY SIBLING RIVALRY OR JEALOUSY?……....	☐ NO	☐ YES
ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly……	☐ NO	☐ YES
DO PARENTS OR CAREGIVERS EVER SMOKE?……..	☐ NO	☐ YES
ANY REACTIONS TO PREVIOUS IMMUNIZATIONS?……	☐ NO	☐ YES
ANYBODY AT HOME WITH A DECREASED IMMUNE SYSTEM (examples Cancer, HIV……..	☐ NO	☐ YES
IS REAR FACING CAR SEAT USED ALL THE TIME?……	☐ NO	☐ YES
HAVE SMOKE ALARMS?……	☐ NO	☐ YES
ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)? ……..	☐ NO	☐ YES
HOUSE BUILT BEFORE 1980, OR LOCATED NEAR LEAD-RELATED INDUSTRIES?.....	☐ NO	☐ YES
HOUSEHOLD MEMBER/CLOSE CONTACT WITH HIGH LEAD WORK/HOBBY EXPOSURE?..	☐ NO	☐ YES
OTHER LEAD EXPOSURE (I.E.: EATS NON-FOOD ITEMS / PICA; USE ANTIQUE DISHES, ETC; USE PRODUCTS FROM OTHER COUNTRIES SUCH AS HEALTH REMEDIES, ETC.)……	☐ NO	☐ YES

DESCRIBE BOWEL HABITS (No./ DAY)_____CONSISTENCY/ COLOR_____
NUMBER OF WET DIAPERS PER DAY:_____

DESCRIBE PERSONALITY:_____
SLEEP: HOURS PER DAY? _____ POSITION (SIDE/BACK/BELLY)_____ IN OWN BASINETTE OR CRIB? _____

WHO LIVES IN HOME?_____
DESCRIBE WORK/DAY CARE SITUATION:_____

DEVELOPMENT: (FILLED OUT BY PARENT OR GAURDIAN)

ANY CONCERNS ABOUT VISION OR HEARING?……	☐ NO	☐ YES
BRINGS OBJECTS TO MOUTH?……	☐ NO	☐ YES
FOLLOWS MOVING OBJECTS WITH EYES?……	☐ NO	☐ YES
GRASPS OR HOLD RATTLE?……	☐ NO	☐ YES
LAUGHS OUT LOUD WITHOUT BEING TICKLED OR TOUCHED?……	☐ NO	☐ YES
LIFT HIS/HER HEAD UP WHILE ON HIS/HER BELLY?……	☐ NO	☐ YES
PLAYS WITH HIS/HER HANDS BY TOUCHING THEM TOGETHER?……	☐ NO	☐ YES
RESPONDS TO SOUNDS?……..	☐ NO	☐ YES
ROLLS OVER?……..	☐ NO	☐ YES
SITS WITH SUPPORT?……	☐ NO	☐ YES
STANDS WITH SUPPORT WHEN HOLDING BABY BY HANDS/ARM?……	☐ NO	☐ YES