

**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