

Jessica Davis MD

The New Mom's Family Doctor
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FOUR MONTH WELL CHILD VISIT

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES			DISCUSSION TOPICS	
Yes	No	Overall, I feel confident that my child is doing well	General questions Family Support Childcare arrangements Postpartum Depression Infant temperament *****	
Yes	No	I have enough help with the baby		
No	Yes	There have been recent changes or stresses in our family Who cares for your baby during the day? _____		
No	Yes	I am having some "baby blues" Describe your baby's personality: _____		
FEEDING/SLEEPING				
No	Yes	I have questions about my baby's feeding My baby takes breast milk every ___ hrs, or _____ formula, ___ oz every ___ hrs What solid food has your baby tried (if any) _____	Continue breastfeeding Solids optional -waiting fine Iron source by 6 mos Vit D supp if <500cc formula Normal range 2-8 hrs Avoid bottle at bedtime Avoid bottle propping Safe sleep environment Sleep associations Nighttime crying *****	
Yes	No	I am satisfied with my child's sleep schedule. # naps per day _____ #hrs sleep at night _____ Longest sleep period: Daytime _____ Nighttime _____ How do you get your baby to sleep? Feeding / Rocking / Pacifier / Self / Other Where does your baby sleep? _____		
VOIDING / STOOLING				
No	Yes	My baby poops and pees normally Wet diapers _____ Stool diapers _____ (per day)		Normal variations *****
BEHAVIOR / DEVELOPMENT				
No	Yes	I have questions about my child's development	R-PDQ if concerns Separation anxiety Anticipate rolling / falls Tummy time *****	
Yes	No	My baby recognizes my voice		
Yes	No	My baby looks from one side to the other		
Yes	No	My baby laughs and squeals		
Yes	No	My baby holds his/her head steady		
Yes	No	My baby reaches for and grabs objects		
Yes	No	My baby puts his/her hands together		
PREVENTION				
No	Yes	My baby lives with someone who smokes cigarettes	Risk of tobacco exposure Assess TB risk Car seat rear facing until at least 20lbs and 1 year old SIDS prevention Crib safety Teething, cleaning teeth Burn prevention Water safety Injuries #1 cause of death Everything goes to mouth Poison control 800-222-1222	
No	Yes	My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa		
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No	Yes	I have a family member who has had Tuberculosis		
Yes	No	I always keep my child in a car seat and in the back seat		
Yes	No	My baby sleeps only on his/her side or back		
Yes	No	I have smoke alarms and test them regularly		
Yes	No	My hot water heater is set to 120°F		
No	Yes	I have concerns that my baby is not safe at home or daycare		
Yes	No	My house is "child-proofed"		
Yes	No	I know how to take a temperature and treat a minor cold		
No	Yes	I have questions about immunizations/shots		
No	Yes	Is there anything else you want to discuss today?		