Four Seasons Pediatrics

Well Visit Form for 1st Office Visit, 1 Month Visit, 6-8 Week Visit

Please tab through each field to fill out, or select from the drop-down menu

Child's Name: ________________________ Birth Date: _________ Age: ______
Today's Date: _________
Any change in address, if so list new information:

____

Birth History:

Birth Weight: ______ pounds ______ ounces
Please list any problems during the pregnancy or delivery:

____

Feeding History:

What kind of milk (breast or formula and type) does your baby take? ___________________
If Bottle-fed – ounces usually ingested in 24 hours: _____________
If Breast-fed: # feedings/24 hours: _______ (please note we recommend Tri Vi Sol OTC vitamins)
Is your baby on solids? ________
Does your baby often have diarrhea? __________
Does your baby have a good stream of urine? __________

Behavior:

Any problems with your babies sleeping? ____
How much does your baby cry? _______________________

Illnesses:

If your baby is on medicines, name them: ____
Has your baby had any serious illnesses since the last check up? __________

Development (for 2 month olds only): Please mark a check in the box if your child does the following:

Your baby raises his/her head when lying on the stomach
Your baby smiles at you
Your baby follows your movements when you move from one side to the other

Social:

Do you feel you are coping well with a new child at home? __________
Are both parents living at home? __________