Four Seasons Pediatrics

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

Child's Name: ________________________ Birth Date: _________ Age: ______
Today's Date: _________

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? __________
- Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? __________
- Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? _________

Vaccine Information Statements (Check One)

[ ] I will review the in-room copy
[ ] I will review the on-line copy at your website
[ ] I would like a paper copy

Other

[ ] There are concerns about family mental health or substance use in the home
[ ] There are concerns about firearms in the home