

# WELL CHILD EXAM-INFANCY: 4 Months

DATE \_\_\_\_\_

PATIENT NAME	DOB	SEX	PARENT NAME
Allergies		Current Medications	

Prenatal/Family History	Chief Complaints
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Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP (if risk)
	%		%		%				

Birth History  Vaginal  C-Section  
 Birth Wt.: \_\_\_\_\_ Gestation: \_\_\_\_\_ Complications  Y  N

**Interval History:**  
 (Include injury/illness, visits to other health care providers, changes in family or home)

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Apnea  Y  N  Monitor  
**Nutrition**  
 Breast every \_\_\_\_\_ hours  
 Formula \_\_\_\_\_ oz every \_\_\_\_\_ hours  
 With iron  Y  N  
 Type or brand \_\_\_\_\_

City water  Well water  
 Solids  Y  N  
**Elimination**  
 Normal  Abnormal  
**Sleep**  
 Normal (5-6 hours at night)  Abnormal  
 Additional area for comments on page 2

**WIC**  Y  N  
 Maternal Infant Health Managed Care Program (MCP)  
 Y  N Name: \_\_\_\_\_

**Screening and Procedures:**  
 Subjective Hearing -Parental observation/ concerns  
 Subjective Vision -Parental observation/ concerns  
**Developmental Surveillance**  
 Social-Emotional  Communicative  
 Cognitive  Physical Development  
**Psychosocial/Behavioral Assessment**  
 Y  N  
**Screening for Abuse**  Y  N  
**If At Risk**  
 Labs Done Today  Y  N  
 Hct or Hgb \_\_\_\_\_

**Immunizations:**  
 Follow AAP/AAFP/CDC guidelines  
 Immunizations Reviewed  
 Immunizations Given & Charted – *if not given, document rationale*  
 IMPACTSIIS checked/updated  
 Acetaminophen \_\_\_\_\_ mg. q. 4 hours

Patient Unclothed  Y  N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Abnormal Findings and Comments

( see additional note area on next page)

Results of visit discussed with parent  Y  N  
**Plan**

History/Problem List/Meds Updated  
 Referrals  
 WIC  Help Me Grow™  Transportation  
 Maternal Infant Health MCP  
 Children Special Health Care Needs  
 Other referral \_\_\_\_\_  
 Other \_\_\_\_\_

**Anticipatory Guidance/Health Education**  
 (✓ if discussed)

**Safety**  
 Appropriate car seat placed in back seat  
 Use safety belt and don't drive under the influence of alcohol or drugs  
 Keep home and car smoke-free  
 Don't leave baby alone in tub or high places; always keep hand on baby  
 Water temp. <120 degrees/test with wrist  
 Don't use baby walkers  
 Check home for sources of lead

**Nutrition**  
 Breastfeed or give iron-fortified formula  
 Avoid foods that contribute to allergies  
 Introduce solid foods at 4-6 months  
 Wait one week or more to add new food

**Oral Health**  
 Discuss teething  
 Discuss good family oral health habits  
 Don't share spoon or put pacifier in your mouth to clean.

**Infant Development**  
 Consoling a fussy baby  
 Put baby to sleep on back/Safe Sleep  
 Learn baby's temperament  
 Talk, sing, play music, and read to baby  
 Establish daily and bedtime routines

**Family Adjustment**  
 Encourage partner to help care for infant  
 Take time for self and spend time alone with your partner  
 Keep in contact with friends, family  
 Family Planning  
 Choose responsible babysitters  
 Discuss child care, returning to work  
 Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression  
 Baby cannot be spoiled by holding, cuddling or rocking  
 Other Anticipatory Guidance Discussed:

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**Next Well Check: 6 months of age**

**Developmental Questions and Observations on Page 2**

Provider Signature: \_\_\_\_\_

## WELL CHILD EXAM-INFANCY: 4 Months

DATE	PATIENT NAME	DOB
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### Developmental Questions and Observations

Ask the parent to respond to the following statements about the infant:

- |  |                          |   |
|--|--------------------------|---|
| <b>Yes</b>                               | <b>No</b>                |   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | Please tell me any concerns about the way your baby is behaving or developing |
| <hr style="border: 0.5px solid black;"/> |                          |   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby cries when upset and seeks comfort.                                   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby smiles and laughs.  |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby is sleeping well.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby is eating and growing well.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby can see and hear.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby likes to look at and be with me.                                      |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby reaches for objects and can hold them.                                |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby rolls or tries to roll over from tummy to back.                       |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby lets me know what it wants and needs.                                 |

Ask the parent to respond to the following statements:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | I am sad more often than I am happy.                          |
| <input type="checkbox"/> | <input type="checkbox"/> | I have more good days with my baby than bad days.             |
| <input type="checkbox"/> | <input type="checkbox"/> | I have people who help me when I get frustrated with my baby. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am enjoying my baby more days than not.                     |

Provider to follow up as necessary

### Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool. Tool Used \_\_\_\_\_).

Infant Development			Parent Development		
Holds head upright in prone position	Yes	No	Looks at infant and shares baby's smiles	Yes	No
Laughs responsively	Yes	No	The parent comforts baby effectively	Yes	No
Follows past midline	Yes	No	Parent and baby are interested in and respond to each other	Yes	No
No persistent fist clenching	Yes	No	Parent seems depressed, angry, tired, overwhelmed, or uncomfortable	Yes	No
Raises body on hands	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. ( <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> )		
Seeks eye contact with parent	Yes	No			

### Additional Notes from pages 1 and 2:

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Staff Signature: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

## **Your Baby's Health at 4 Months**

### Milestones

*Ways your baby is developing between 4 and 6 months of age.*

- Babbles using single consonants such as “dada” or “baba”
- Smiles, laughs, and squeals responsively
- Rolls over from front to back
- Shows interest in toys
- Tries to pass toys from one hand to the other
- May get upset when separated from familiar person(s)
- Sits with support
- Enjoys a daily routine

### For Help or More Information:

#### **Breast feeding, food and health information:**

- Women, Infant, and Children (WIC) Program, call 1-800-755-4769, or visit the website at: [www.odh.ohio.gov/odhPrograms/ns/wicn/wic1.aspx](http://www.odh.ohio.gov/odhPrograms/ns/wicn/wic1.aspx)
- The National Women's Health Information Center Breastfeeding Helpline. Call 1-800-994-9662, or visit the website at: [www.4woman.gov/breastfeeding](http://www.4woman.gov/breastfeeding)
- LA LECHE League – 1-800-LALECHE (525-3243). Visit the website at: [www.lalecheleague.org](http://www.lalecheleague.org)

#### **For families of children with special health care needs:**

Bureau for Children with Medical Handicaps, ODH  
1-800-755-4769 (Parents) Visit the Website at:  
<http://www.odh.ohio.gov/odhPrograms/cmhc/cwmh/bcmh1.aspx>

**Social Support Services:** Contact the local county Department of Job and Family Services Healthchek Coordinator

#### **Car seat safety:**

- Contact the Auto Safety Hotline at 1-888-327-4236. Visit the website: <http://www.safercar.gov/>
- To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at [www.seatcheck.org](http://www.seatcheck.org)

#### **If you're concerned about your child's development:**

Contact Help Me Grow at 1-800-755-GROW (4769) or at [www.ohiohelpmegrow.org/](http://www.ohiohelpmegrow.org/).

#### **For information about childhood immunizations:**

Call the National Immunization Program Hotlines at 1 (800) 232-4636 or online at <http://www.cdc.gov/vaccines>.

#### **For help finding childcare:**

Bureau of Child Care and Development -800.886.3537  
<http://www.odjfs.state.oh.us/cdc/query.asp>

#### **Domestic Violence hotline:**

National Domestic Violence Hotline - (800) 799-SAFE (7233) or online at <http://www.ndvh.org/>

### Safety Tips

Always keep one hand on your baby when he is on a bed, sofa, or changing table so he does not roll off.

Never leave your baby alone in your home, car or community.

### Safety Tips

Use a rear-facing car seat for your baby on every ride. Buckle her up in the back seat, away from the air bag.

Keep the Poison Control Center phone number by your phone: 1-800-222-1222

### Health Tips

Check-ups are a good time to ask the doctor or nurse questions about your baby. Make a list of questions before you go.

Keep your baby's immunization (shot) card in a safe place and bring it to every doctor or clinic visit. Babies can get shots even when they have a slight cold.

Your baby is still getting all the nutrition he needs from breast milk or formula. Try to keep breast-feeding until your baby is at least 12 months old. Talk to your doctor about when to start your baby on cereal or other solid foods. This usually happens when your baby is 5 or 6 months old.

Check how your baby sees and hears. Watch to see if her eyes follow moving objects. Watch to see if she turns toward a loud or sudden sound.

Keep putting your baby to sleep on his back. Keep soft bedding and stuffed toys out of the crib. Make sure your baby sleeps by himself in a crib or portable crib.

Call your baby's doctor or nurse before your next visit if you have any questions or concerns about your baby's health, growth, or development.

### Parenting Tips

Sing, talk, read to and play with your baby every day. Look at your baby and repeat the sounds she makes.

Put your baby on his tummy to play on the floor. Put toys close to him so he can reach for them.

Try to make a daily routine for you and your baby.

When you are a parent, you will be happy, mad, sad, frustrated, angry, and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call Cooperative Extension for classes-614. 688.5378
4. Call 800.448.3000 or visit Boystown Parenting Hotline at (<http://www.parenting.org/hotline/index.asp>) They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day.