4 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ______________________

Name: ______________________________________ DOB:___________ Male Female

Physician Signature:______________________________________

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	**NO**	**YES**
Is your baby crying longer than 30 minutes at a time?	**NO**	**YES**
Do they have severe nasal stuffiness?	**NO**	**YES**
Do you have concerns about skin color or rash?	**NO**	**YES**
Are they wheezing?	**NO**	**YES**
Did they have any problems with previous immunizations?	**NO**	**YES**
Feeding/ Nutrition		
Is your child breast feeding well?	**YES**	**NO**
How often?		
For how long? (minutes)		
Is your child taking formula well?	**YES**	**NO**
How often?		
How many ounces?		
Which formula?		
Are you feeding baby any solid foods?	**NO**	**YES**
Is your baby taking a vitamin supplement?	**NO**	**YES**
Oral Health		
Do parents regularly see a dentist, brush and floss teeth?	**YES**	**NO**
Do you put your baby to bed with a bottle?	**NO**	**YES**
Elimination		
Are they having problems with bowel movements (pooping)?	**NO**	**YES**
Are they urinating (peeing) well?	YES	NO
Sleep		
Do they sleep five or more hours at a time?	**YES**	**NO**
Do you have questions about sleep habits?	**NO**	**YES**
Do you put baby in the crib when drowsy, not fully asleep?	**YES**	**NO**
Does your baby wake at night to eat?	**NO**	**YES**

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Name: ______________________________________ DOB:__________

Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	**NO**	**YES**
Siblings adjusting well to the newborn?	**YES**	**NO**
Are you having family stress?	**NO**	**YES**
Do you ever worry your family will go hungry?	**NO**	**YES**
Do you have daycare concerns?	**NO**	**YES**
Development		
Does your baby smile when approached?	**YES**	**NO**
Does your baby coo, babble, and laugh?	**YES**	**NO**
Does your baby have different cries to indicate hunger, tiredness, and pain?	**YES**	**NO**
Does your baby move all extremities well?	**YES**	**NO**
Do they roll?	**YES**	**NO**
Are they able to lift their upper body on their elbows?	**YES**	**NO**
Do they lift their head well when lying on their tummy?	**YES**	**NO**
Do they have good head control?	**YES**	**NO**
Do you hold, cuddle, talk, and play with your baby?	**YES**	**NO**
Safety		
Does your baby sleep on his/her back?	**YES**	**NO**
Does your baby sleep in a bassinet or crib and not parents' bed?	**YES**	**NO**
Do you always keep a hand on baby when placed above the floor?	**YES**	**NO**
Does your baby wear any jewelry including necklaces?	**NO**	**YES**
Do you hold or carry hot liquids around the baby?	**NO**	**YES**
Do you keep plastic bags and latex balloons away from your baby?	**YES**	**NO**
Does your baby ride in a rear facing safety seat, in the back seat?	**YES**	**NO**
Is your baby exposed to anyone who smokes?	**NO**	**YES**
Are there working smoke detectors and carbon monoxide detectors in the home?	**YES**	**NO**
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	**YES**	**NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	**NO**	**YES**
Has a family member or contact had a positive TB skin test (PPD)?	**NO**	**YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	**NO**	**YES**
Has your baby traveled to a high-risk country for more than a week?	**NO**	**YES**