Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

2 – 4 Month Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Has your baby been fussier than expected? .... Y N
2. Do you have any concerns about how your baby is feeding? .... Y N
3. Do you give your baby a vitamin supplement? .... Y N
4. How long does your baby sleep at night without awakening or feeding? Hours ______
5. Do you have any concerns about your baby's vision? .... Y N
6. Do you have any concerns about your baby's hearing? .... Y N

SAFETY

7. Do you always use a rear facing car seat positioned in the back seat? .... Y N
8. Does your baby always sleep on his/her back? .... Y N
9. Do you know infant CPR and first aid? .... Y N
   (www.americanheart.org - search infant CPR Anytime)
10. Does your baby spend time with anyone that smokes? .... Y N
11. Is there a gun in your home? .... Y N
    If yes, is it locked?... Y N
12. Do you have concerns regarding violence in your home? .... Y N
13. Do you have working smoke alarms and carbon monoxide detectors in your home? .. Y N
14. Is your water heater set below 120 degrees? .... Y N
15. Do you ever drink very hot beverages while holding your baby? .... Y N

SOCIAL

16. Are you getting enough rest? .... Y N
17. Do you and your partner have any time to yourselves? .... Y N
18. If you work outside the home, have you returned to school or work? .... Y N
    If yes, is your baby in daycare? .... Y N
19. Are there any new stresses or recent changes impacting your family
    (job change, move, divorce, illness)?... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date