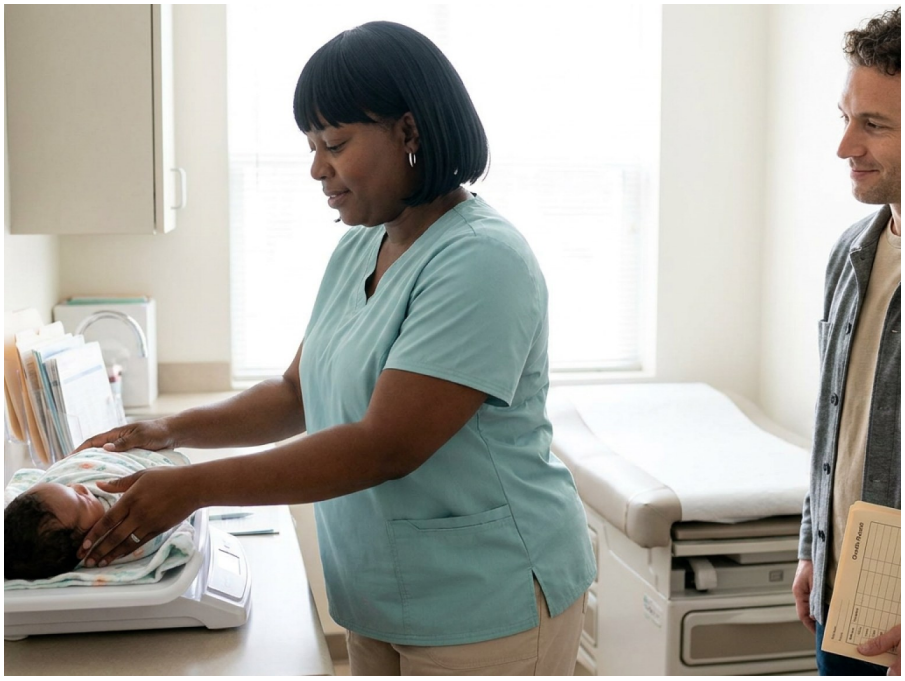
Baby weight chart by month



How baby weight charts work

Infant growth charts are clinical tools that plot a baby’s measurement against age and sex. For weight, the measurement is usually shown as weight-for-age. The World Health Organization Child Growth Standards provide weight-for-age charts and z-score tables for boys and girls from birth to 2 years. These standards are widely used because they describe growth patterns in healthy children under optimal conditions.

Many parents focus on percentiles. A baby on the 25th percentile for weight weighs more than about 25 out of 100 babies of the same age and sex, and less than about 75 out of 100. A baby on the 75th percentile is not automatically healthier than a baby on the 25th percentile. The key question is whether the baby’s plotted points follow a reasonably consistent curve.

Growth charts also use z-scores, which describe how far a measurement is from the reference median. Clinicians may use z-scores when they need more precision, particularly in public health, nutrition assessment, or complex medical care. For families, percentiles are often easier to visualize, but both methods are ways of describing the same growth data.

Baby weight chart by month: what to expect

The numbers below are best understood as broad, practical expectations rather than targets. Exact values differ by sex, birth weight, gestational age, genetics, feeding method, and health history. Your baby's own plotted curve is usually more informative than comparison with another baby.

Birth: Many term newborns weigh roughly 2.5 to 4.5 kg, but individual variation is common. Newborns often lose some weight in the first days after birth before regaining it.
1 month: Weight gain is usually becoming established. Feeding assessment is important if the baby has not regained birth weight within the timeframe advised by the clinician.
2 months: Many babies are gaining steadily, and weight checks can help confirm that milk transfer or formula intake is adequate.
3 months: Rapid early growth often continues. Some babies begin to show a clearer personal growth channel on the chart.
4 months: Weight gain may still be robust, although week-to-week fluctuations are common.
5 months: Babies may become more active, but milk remains the main source of nutrition for most infants at this age.
6 months: Growth has often been fastest during the first 6 months. Around this age, many babies begin complementary foods around 6 months while continuing breast milk or infant formula.
7 months: Weight gain typically continues but may be slower than in early infancy. Appetite can vary with teething, minor illness, and sleep disruption.
8 months: Increased movement, such as rolling, pivoting, or crawling attempts, may coincide with a more gradual rate of gain.
9 months: A varied diet becomes more relevant, but milk still contributes significant calories and nutrients.
10 months: Weight curves may appear less steep than earlier months. This can be normal if the baby is active, feeding well, and developing appropriately.
11 months: Growth should still trend upward, though not necessarily in a perfectly smooth line.
12 months: By the first birthday, many babies have roughly tripled birth weight, but this is only a general observation and not a rule for every child.

How often should a baby be weighed?

Routine weighing schedules vary by country, clinic, and individual circumstances. The NHS advises that babies are usually weighed monthly up to 6 months, every 2 months from 6 to 12 months, and every 3 months after the first year, unless there are concerns. More frequent weighing is not always better, because small day-to-day changes can reflect feeding timing, stool or urine output, clothing, or scale differences.

Healthcare professionals may recommend additional weight checks if a baby was born preterm, had low birth weight, has feeding difficulties, has a medical condition, or has shown unexpected changes on the growth chart. Conversely, a thriving baby who is feeding well and following a stable curve may not need very frequent measurements.

For accuracy, try to use the same type of calibrated infant scale when possible. Babies are ideally weighed without heavy clothing or a full diaper. If you are tracking at home, remember that home scales may not match clinical scales precisely, so bring your notes to appointments rather than making major decisions from isolated readings.

Percentiles: what is normal and what is concerning?

A baby's percentile is not a grade. Some babies naturally track along a lower percentile, while others track along a higher one. A baby who remains close to the 10th percentile, feeds well, has normal urine and stool patterns, and shows appropriate developmental milestones may be growing normally for that child. Similarly, a baby on a high percentile may be healthy if the pattern is consistent and the clinician has no concerns.

What deserves attention is a change in trajectory. If a baby drops across percentiles unexpectedly, rises very rapidly, or has a flat or downward weight curve, a healthcare professional may want to evaluate feeding, hydration, illness, gastrointestinal symptoms, endocrine issues, or other medical factors. Growth curves should generally move upward with age, even if the slope varies.

Percentiles should also be interpreted alongside length, head circumference, clinical examination, birth history, and feeding history. Weight alone cannot explain whether growth is proportionate. For example, a baby who is long and

lean may have a different pattern from a baby who is shorter with the same weight percentile.

Feeding, illness, and temporary slowdowns

Feeding is closely linked to infant weight, but weight changes do not automatically mean that a parent is doing something wrong. Breastfeeding supply, latch, milk transfer, formula preparation, reflux symptoms, food allergies, oral-motor coordination, and illness can all affect intake. A structured discussion of a Baby feeding schedule by age may help families understand typical intake patterns, but feeding should remain responsive to the individual baby.

The NHS notes that weight gain can slow temporarily when a baby is unwell and may return to the usual pattern within 2 to 3 weeks. Minor viral infections, vomiting, diarrhea, congestion, and reduced appetite can all influence short-term weight. However, persistent poor intake, fewer wet diapers, signs of dehydration, or ongoing weight faltering should not be watched at home without medical input.

Around 6 months, solids are introduced for developmental and nutritional reasons, but they do not immediately replace milk as the main energy source. Iron-rich foods for babies become important, especially because iron stores from pregnancy begin to decline. If a baby struggles with textures, gagging beyond what seems typical, coughing with feeds, or refusal of feeds, ask about pediatric feeding assessment.

Premature babies and corrected age

For babies born preterm, growth interpretation is more nuanced. Clinicians may use specialized preterm growth references initially and then transition to standard infant growth charts. Corrected age for preterm babies is often used when assessing growth and development. Corrected age means the baby’s age adjusted for the number of weeks early they were born. For example, a baby who is 4 months old but was born 8 weeks early may be assessed more like a 2-month-old in some developmental and growth contexts.

Premature infants may have different nutritional needs, medical follow-up

schedules, and catch-up growth patterns. Some grow steadily but remain small for a while; others gain more quickly after hospital discharge. Because preterm growth is influenced by neonatal history, respiratory status, feeding tolerance, and medical complications, families should rely on their neonatal or pediatric team rather than general charts alone.

How to use a monthly chart without increasing anxiety

It is understandable to feel anxious when looking at numbers. Many caregivers worry that every fluctuation reflects a serious problem. In reality, growth assessment is most useful when it is calm, consistent, and connected to the full clinical picture.

Plot measurements from reliable checks rather than weighing multiple times a day.
Look at the trend over weeks to months, not one isolated reading.
Use the chart that matches the baby's sex and age range.
Tell the clinician about feeding frequency, duration, formula volumes if applicable, diaper output, vomiting, diarrhea, and recent illness.
Ask whether weight is proportionate to length and head circumference.
For preterm infants, ask which age and chart should be used at each stage.

Growth monitoring should support you, not blame you. If feeding feels difficult or weight checks have become emotionally overwhelming, ask for help early. Lactation consultants, pediatric dietitians, health visitors, and pediatricians can often provide practical support.

When to contact a healthcare professional

Contact your baby's healthcare professional if you notice a persistent change in feeding, fewer wet diapers, unusual sleepiness, repeated vomiting, ongoing diarrhea, or if your baby's growth percentile drops unexpectedly. Seek urgent care if your baby appears dehydrated, difficult to wake, has breathing difficulty, has a fever in early infancy according to local urgent-care guidance, or seems seriously unwell.

You should also ask for advice if your baby has not regained birth weight as expected, loses weight after the newborn period, or has a weight curve that

flattens over repeated measurements. These findings do not automatically mean a serious condition is present, but they do warrant careful assessment.