

Date _____ Patient # _____

Name _____ Date of Birth _____

Address _____
_____Lives with: 1 parent 2 parents Other caregiver Others (including siblings) _____

May release information to: (parent, guardian, other family -- list) _____

Parental concerns: _____

Changes in child's health since last visit: _____

GENERAL HEALTH:Nutrition: Breast: _____ times/day
 Bottle _____ oz/day
 Vit D (until 32oz formula per day)**Elimination:** Stooling: soft, easy to pass BMs

Sleep: _____ hours through the night

YES NO

- Place on back to sleep
 Put to bed awake at night and naps
 Bottle to bed?
 Problems: _____

DEVELOPMENT: Screen or refer if concerns or "No" response on milestones in **bold type**

YES NO

- Smiles responsively
 Vocalizes
 Responds to sound
 Follows objects with eyes
 Raises head when prone

Family concerns about growth, development, behavior

_____**MEDICAL HISTORY:**

Perinatal problems: _____

Newborn screening: Normal Abn _____

Medications: _____ Allergies: _____

Major medical illnesses/special health care needs: _____

Hospitalizations: _____

Surgeries: _____

FAMILY HISTORY: Reviewed and updated**SOCIAL HISTORY:**

Childcare: _____

FAMILY RISK FACTORS:

Changes in family since last visit: _____

Stress: How much stress are you and your family under now? None Slight Moderate Severe**What kind of stress?** Relationships Drugs Alcohol Violence/Abuse Lack of help Financial Health Insurance Child care Other _____**How stressful is caring for your child?** None Slight Moderate Severe**MATERNAL/CAREGIVER DEPRESSION:**In the past month, have you/partner felt down, depressed or hopeless? No Sometimes OftenIn the past month have you/partner felt little interest or pleasure in doing things? No Sometimes Often**ANTICIPATORY GUIDANCE:** Check if discussed**FAMILY WELL-BEING:**

- Is mom getting rest? Post-partum checkup? Time for self & partner?
 Sibling adjustment to infant.
 Plan for return to work.
 Resources for local child care

BEHAVIOR:

- Importance of talking, reading, singing cuddling and – **cannot spoil.**
 Learn baby's responses, temperament.
 Sleep environment – firm mattress, no loose bedding, crib slats < 2 3/8". apart

NUTRITION / ORAL HEALTH:

- Vitamin D until taking 32 oz formula
 Safe pumping & storage of breast milk.
 Wait to introduce solids at 4-6 months of age
 No honey until 1 yr.
 Introduce bottle by 2mo if going to daycare
 No bottle propping.

SAFETY:

- Encourage day/night routine and supervised tummy time.
 Reinforce: H₂O heater set to < 120 degrees
 If smoking in home: discuss quitting, limiting exposure
 Rear-facing car seat.
 Baby may roll - always one hand on baby (never leave on changing table, couch, bed.).
 Wash hands.

PHYSICAL EXAMINATION

Vital signs: P: _____ R: _____ T: _____ Weight _____ (_____%)

Length _____ (_____%) Wt/Length % _____ Head circumference _____ (_____%)

N Abn *Comment on abnormal findings*

General appearance _____

Behavior/interaction with family _____

Skin _____

Head/scalp _____

Ears _____

Eyes _____

Nose _____

Mouth/Throat _____

Teeth _____

Neck _____

Back/Chest _____

Lungs _____

Heart _____

Abdomen _____

Genitalia _____

Musculoskeletal _____

Neurologic _____

Results reviewed: (outside info, lab, etc.) _____

Impression: _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations: Vaccine Information Statements offered to parent
 Past adverse reactions to immunizations: No Yes
 See *current guidelines* www.immunize.org/aap

LAB: (if indicated) _____

Developmental Follow-up No delays Follow-up in office Referral

Referral: (if indicated) _____

Central referral numbers: For assistance with care coordination, transportation, or health information for children *birth through age 21*:
Healthy Families Line 1-800-369-2229

For referral of children *birth to age 3* with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts: _____

Return appointment: _____

Signature _____ Date _____