

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: _____

GENERAL HEALTH:

Nutrition: Breast: _____ min per _____ hrs OR
 Formula Type _____ oz per _____ hrs; _____ oz/d

Water source: City tap Filtered/bottled
 Well
 Checked within last 3 mo Yes No

Elimination:

YES NO

Over 6 wet diapers per day _____

Stooling: _____ per day

Problems: _____

Sleep: _____ hours through the night

YES NO

Place on back to sleep

At night and naps, put to bed awake

Problems: _____

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

YES NO

Focuses on faces

Responds to sound

Lifts head briefly when in prone

Moves arms and legs equally

Any concerns about development? _____

MEDICAL HISTORY:

Gestational age _____ Maternal labs _____

Complications: _____

Birth history: NSVD C-section Apgars ____/____

Breech Yes No

Complications: _____

Birth weight _____ D/C weight _____

Passed newborn hearing screen

Neonatal screen done

Results Pending Normal Abn _____

Hepatitis B vaccine given after birth

Medications: _____

Major medical illnesses/Special health care needs: _____

FAMILY HISTORY: Circle if present

Depression or other mental illness, substance use, abuse learning problems, violence, heart disease, hypertension diabetes, kidney disease, deafness, cancer other (note): _____

SOCIAL HISTORY:

Childcare: _____

FAMILY RISK FACTORS:

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 **Often**

In 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:

Rest & sleep when baby does. Encourage partner/family help.

Spend one-on-one time with older sibs and partner

BEHAVIOR:

Follow infant's cues and feed on-demand

"Back to Sleep" and no co-sleeping to prevent SIDS

Calm baby by stroking and gentle rocking; No shaking or hitting

NUTRITION / ORAL HEALTH

Breastfeed at least 8x/24h. Vitamin D supplement, no extra water

Discuss mother's medications if breastfeeding

Normal voids- 6-8/24h. Stools vary

If using formula: prepare/store safely, 2-3 oz q 2-4 hrs, hold baby semi-upright, don't prop bottle

SAFETY:

Decrease home H₂O temp <120 degrees

If smoking in home: discuss quitting, limiting exposure

Check CO & Fire/Smoke Detectors.

Car seat rear-facing until 20# and 1y.

Child Safety Seat Inspection Locator: 866-732-8243, www.seatcheck.org

NEWBORN CARE

Fever is 100.4 F (38.0 C) Call health provider immediately

Post emergency numbers; know infant CPR

Wash hands prior to handling infant; avoid crowds

Avoid direct sunlight

PHYSICAL EXAMINATION

Vital signs: P: _____ R: _____ T: _____ Weight _____ (_____%) Increase of _____ gm/d since last visit
 Length _____ (_____%) Wt/Length _____ % Head circumference _____ (_____%)

N Abn *Comment on abnormal findings*

- General appearance _____
- Skin _____
- Head/scalp _____
- Ears _____
- Eyes _____
- Nose _____
- Mouth/Throat _____
- Neck _____
- Back/Chest _____
- Lungs _____
- Heart _____
- Abdomen _____
- Genitalia _____
- Musculoskeletal _____
- Neurologic _____

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

Impression: _____

PLAN OF CARE (see Anticipatory Guidance)

LAB:

- Bili (if indicated) other if indicated
- Hip ultrasound at 6 wks if breech

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 _____