Iowa Child Health and Development Record

1-4 week Well Exam

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 including cardiac**
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 H_20 temp <120 degrees
- ❑ If smoking in home: discuss quitting, limiting exposure
- ❑ Check CO & Fire/SmokeDetectors.
- ❑ 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

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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) ❑ TB if high risk ❑ 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 _____