Iowa Child Health and Development Record

4 month 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: ______________________________
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	
❑	❑	**Social smile**
❑	❑	**Coos and laughs interactively**
❑	❑	**Able to be comforted**
❑	❑	**Tracks and follows with eyes**
❑	❑	**Good head control**
❑	❑	**Opens hands, grasps rattle**
❑	❑	**Moves arms and legs equally**
❑	❑	**Lifts head 90 degrees in prone**
❑	❑	May roll over and bear weight on legs

Family concerns about growth, development, behavior

____

____

MEDICAL HISTORY:

Allergies:__________________Meds:___________________

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 ❑ **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:
- ❑ Make time for self, partner and family/friends. Quality child care.
- ❑ Discuss adjustment of older sibs

BEHAVIOR:
- ❑ Range of infant behaviors and temperaments. Calming strategies.
- ❑ Bedtime and feeding routines enhance sense of security.
- ❑ Teach infant to put self to sleep. Crying won't hurt baby.

NUTRITION / ORAL HEALTH:
- ❑ Solid food readiness, don't share spoon.
- ❑ Ask about supplements, herbs, and vitamins
- ❑ No bottle propping or bottle in bed.
- ❑ Discuss teething & family oral health.

SAFETY:
- ❑ May roll and put things in mouth (small objects, plastic bags)
- ❑ Discuss lead in home (espec. before 1960) & parental occupational hazards - farmers, plumbers, welders
- ❑ If smoking in home: discuss quitting, limiting exposure

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: ❑ Hb/Hct if high risk ❑ other 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 ______________