Iowa Child Health and Development Record

6 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

YES	NO	
❑	❑	Drinking from cup?
❑	❑	Solids?: ❑ Cereals ❑ Fruits ❑ Vegetables ❑ Meats ❑ Table / fingerfoods
❑	❑	Juice? If so, _____oz./day

Daily oral health care? ❑ Yes ❑ No ❑ No teeth

Elimination:

❑ Stooling: soft, easy to pass BMs

Sleep:____hours through the night

YES	NO	
❑	❑	Problems? Night feedings?:_________________
❑	❑	Bottle to bed?

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

YES	NO	
❑	❑	**Interacts with family by smiling and vocalizing**
❑	❑	**Shows range of emotions.**
❑	❑	**Turns to voice.**
❑	❑	**Babbles and coos.**
❑	❑	**Rolls over both ways**
❑	❑	**Reaches for objects**
❑	❑	**No head lag when pulled to sitting**
❑	❑	**Bears weight on legs**
❑	❑	May sit without support

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:

- ❑ Encourage support system, time for self, partner, family.
- ❑ Consistency in routines at home and in daycare

BEHAVIOR:

- ❑ Encourage reading, singing, and talking with infant.
- ❑ Discuss causes of fussiness – overstimulation, fatigue, boredom.
- ❑ Sleep routine – self-calming, putting self to sleep. What to do if wakes during night

NUTRITION / OBESITY PREVENTION / ORAL HEALTH

- ❑ Feed infant based on hunger cues. Soft finger foods.
- ❑ Avoid milk, fish, shellfish, egg whites, peanuts, and nuts
- ❑ Limit juice < 2 oz a day. Begin sippy cup.
- ❑ No bottles in bed, no bottle propping.
- ❑ Smear of fluoride-containing toothpaste and soft toothbrush when teeth erupt.
- ❑ Refer to dental home within 6 mos of first tooth.

SAFETY:

- ❑ Never leave infant alone near water, on high places (changing table, couch, bed,etc).
- ❑ Childproof home, barriers in front of heat sources.
- ❑ Lower crib mattress – may pull to stand, back to sleep, no loose bedding.
- ❑ Poison control on every phone: 1-800-222-1222.
- ❑ If smoking in home: discuss quitting, limiting exposure

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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: ❏ Lead and TB if high risk ❏ (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 ________________