

Name				Accompanied by	
Date	MRN	Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Preferred Language	

ATTACH LABEL

CAREGIVER CONCERNS/INTERVAL HISTORY:  None

- PAST MEDICAL HISTORY**  Reviewed and updated
- SURGICAL HISTORY**  Reviewed and updated
- FAMILY HISTORY**  Reviewed and updated

- MEDICATIONS**  None  
 Reviewed and updated
- ALLERGIES**  No known drug allergies  
 \_\_\_\_\_

- Nutrition:**  Breast feeding: \_\_\_\_\_ times/day  
 Pumped breast milk \_\_\_\_\_ oz/day  
 Formula \_\_\_\_\_ oz/day  
 Vitamin D (When breastfeeding)  
 Multivitamin with iron (for premature infants)

- Water Source:**  City tap  Filtered/bottled  
 Well: regularly tested?  Yes  No

- Elimination: YES NO**  
  Soft, easy to pass BMs \_\_\_\_\_  
  Issues with constipation \_\_\_\_\_  
  Normal urine stream \_\_\_\_\_

- Sleep:** Longest sleep stretch through the night \_\_\_\_ hrs  
**YES NO**  
  Safe sleep environment \_\_\_\_\_  
  Put to bed awake at night and naps \_\_\_\_\_  
  Back to sleep \_\_\_\_\_  
  Bottle in bed \_\_\_\_\_

- Newborn Screening:** Metabolic  Normal  Abnormal  
Hearing  Pass  Refer/Fail  
Critical congenital heart disease  Pass  Fail

## RISK ASSESSMENT

- |                       |                       |                        |
|-----------------------|-----------------------|------------------------|
| <b>HIGH</b>           | <b>LOW</b>            |                        |
| <input type="radio"/> | <input type="radio"/> | Vision Concerns _____  |
| <input type="radio"/> | <input type="radio"/> | Hearing Concerns _____ |

## DEVELOPMENT: Screen or refer if concerns

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <b>YES</b>            | <b>NO</b>             |   |
| <input type="radio"/> | <input type="radio"/> | Looks at your face                      |
| <input type="radio"/> | <input type="radio"/> | Smiles when you talk to or smile at her |
| <input type="radio"/> | <input type="radio"/> | Makes sounds other than crying          |
| <input type="radio"/> | <input type="radio"/> | Reacts to loud sounds                   |
| <input type="radio"/> | <input type="radio"/> | Watches you as you move                 |
| <input type="radio"/> | <input type="radio"/> | Looks at a toy for several seconds      |
| <input type="radio"/> | <input type="radio"/> | Holds head up when on tummy             |
| <input type="radio"/> | <input type="radio"/> | Moves both arms and both legs           |

Caregiver concerns about development:

## SOCIAL HISTORY: Reviewed and updated

Lives with:  1 parent  2 parents  Other caregiver

Others (including siblings):

## FAMILY RISK FACTORS:

Changes in family since last visit:

Caregiver job status:

## Do you need additional assistance with any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Getting enough to eat | <input type="checkbox"/> Relationships | <input type="checkbox"/> Drug abuse    |
| <input type="checkbox"/> Violence/Abuse        | <input type="checkbox"/> Financial     | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Health Insurance      | <input type="checkbox"/> Child care    |  |
| <input type="checkbox"/> Other _____           |  |  |

## Maternal/Caregiver PHQ2 Depression Screening:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- 0-Not at all 1-Several days  
2-More than half the days 3-Nearly every day

Little interest or pleasure in doing things 0  1  2  3   
Feeling down, depressed, or hopeless 0  1  2  3   
Total score \_\_\_\_\_

**For scores 3 or over please complete PHQ9**

**PHYSICAL EXAMINATION**

Length _____ cm ( _____ %ile)	Weight _____ Kg ( _____ %ile)	Head circumference _____ cm ( _____ %ile)
<b>VITALS:</b>	Temp: _____	BP (if high risk) ____/____ ( _____ %ile _____ %ile)
	HR: _____	Resp Rate: _____ SpO2 _____

**Normal examination findings are listed below. Describe other findings in the area provided.**

**General:** Well appearing, active, and alert. \_\_\_\_\_

**Head:** Normocephalic and atraumatic. Anterior fontanelle open and flat. \_\_\_\_\_

**Eyes:** Red reflex, present bilaterally. Pupils equal, round, and reactive to light. No discharge. \_\_\_\_\_

**ENT:** No ear deformities. Normal external canals. Tympanic membranes clear bilaterally. Nares patent. \_\_\_\_\_

**Mouth:** No oral lesions or thrush. \_\_\_\_\_

**Neck:** Supple, with full range of motion. \_\_\_\_\_

**Cardiovascular:** Regular rate and rhythm. Heart sounds S1, S2 normal. No murmur. \_\_\_\_\_

**Chest:** No increased work of breathing. Clear and symmetric breath sounds bilaterally. \_\_\_\_\_

**Abdomen:** Soft, non-distended, no masses, no hepatosplenomegaly. \_\_\_\_\_

**Genitourinary:** \_\_\_\_\_

Normal female external genitalia. \_\_\_\_\_

Normal male external genitalia. Testes descended bilaterally, no scrotal swelling, no inguinal hernia. \_\_\_\_\_

**Musculoskeletal:** Spine normal. Negative Ortolani and Barlow maneuvers. Moves all extremities symmetrically. \_\_\_\_\_

**Neurological:** Normal strength and tone. \_\_\_\_\_

**Skin:** Normal color. No lesions. \_\_\_\_\_

Birthmarks (if applicable) \_\_\_\_\_

Other comments:

ATTACH LABEL

**ANTICIPATORY GUIDANCE:**

**FAMILY WELL-BEING:**

- Self-care for caregivers
- Post-partum checkup
- Sibling adjustment to infant
- Family support
- Plan for return to work
- Resources for local child care

**FAMILY NUTRITION/ORAL HEALTH:**

- Safe pumping & storage of breast milk
- Wait to introduce solids until around 6 months of age
- No honey until 1 year
- No bottle propping

**BEHAVIOR:**

- Importance of talking, reading, singing, cuddling
- Learn baby's responses, temperament

**SAFETY:**

- Sleep environment—firm mattress, no loose bedding, crib slats < 2 3/8" apart
- Encourage day/night routine and supervised tummy time
- Safe sleep practices
- No swaddling after 2 months
- Water heater set below 120°
- 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 before feeding and after diaper changes
- Pertussis vaccine for adults in household
- Influenza and Covid-19 vaccine for household contacts

**ASSESSMENT**

**Well Child Exam**

- Normal findings (normal interval growth, age appropriate development)
- Abnormal findings \_\_\_\_\_

**PLAN OF CARE** (see Anticipatory Guidance)

**Immunizations:**

- Vaccine Information Statements given
- Vaccine counseling given
- Vaccines due:
  - HepB
  - DTaP
  - Rotavirus
  - Hib
  - PCV13
  - IPV

Catch-up vaccinations given \_\_\_\_\_

High risk:  MenACWY-CRM (Menveo) ≥2 mos

Past adverse reactions to immunizations:

No  Yes \_\_\_\_\_

See **current guidelines:** <https://www.cdc.gov/vaccines/index.html>

**LAB:** (if indicated)

**Developmental Follow-up:**

- No delays
- Follow-up in office
- Referral

**Referral:** (if indicated)  Vision

**1st Five Healthy Mental Development Initiative:** In available counties, contact 1st Five for developmental concerns or needs assessment at [idph.iowa.gov/1stfive](http://idph.iowa.gov/1stfive)

**Early ACCESS Line:** For referral of children birth to age 3 with developmental delay to local Early Access providers, call (888) 425-4371 or go to: [iafamilysupportnetwork.org](http://iafamilysupportnetwork.org)

**Healthy Families Line:** For assistance with care coordination, transportation, or health information for children birth through age 21 call (800) 369-2229

**Return appointment:**

- Follow-up in 2 months \_\_\_\_\_
- Follow-up hearing screen if at risk \_\_\_\_\_
- Other/referral based on risk assessment \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**NOTES**

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