PEDIATRIC VISIT 0 to 1 MONTH

DATE OF SERVICE_________________
M / F   DATE OF BIRTH_____________  AGE_________

WEIGHT_________/_______%   HEIGHT_________/_______%   HC_________/_______%   TEMP_____________

HISTORY:
Family health history documented & updated?_____________
Perinatal history documented & updated?_________________
Concerns: _____________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep:   Child care:
Maternal Depression?   Yes / No
Support? ____________________________________________

Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other___________________________

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

Risk Assessment: TB Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl  Abn  (describe abnormalities)

☐ ☐   Appearance/Interaction
☐ ☐   Growth

☐ ☐   Skin/Umbilicus

☐ ☐   Head/Face/Fontanelles
☐ ☐   Eyes/Red reflex/Cover test
☐ ☐   Ears
☐ ☐   Nose
☐ ☐   Mouth/Gums

☐ ☐   Neck/Nodes
☐ ☐   Lungs

☐ ☐   Heart/Pulses
☐ ☐   Chest/Breasts

☐ ☐   Abdomen
☐ ☐   Genitals/Circumcision

☐ ☐   Extremities/Heips/Feet
☐ ☐   Neuro/Reflexes/Tone

☐ ☐   Vision (gross assessment)
☐ ☐   Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:
Breast/bottle: Amount & frequency ______________________

Bowel/bladder: Number of wet______, dry______ in 24 hours?
Number BM's in 24 hours? __________

Education: Hold to feed □  Use of pacifier □
If breast fed, Vitamin D □  Feed on demand □  Growth spurts □

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Regards face □  Alert □  Social smile □
Fine Motor: Follows 90 degrees □  Grasps □
Language: Coos □  Laughs □
Gross Motor: Head steady when sitting □  Hand brought to mouth □

ANTICIPATORY GUIDANCE:
Social: Time out for parent □  Parental adjustment □
Sibling rivalry □

Parenting: Respond to cry □  Trust-building □  Holding, comfort □

Play and communication: Crying is communication □
Voices, mobiles, music, pictures □

Health: Diaper/skin care □  Bathing & washing hair □
Sneezing, hiccoughs, soft spot □
Taking baby's temperature □  Second hand smoke □

Injury prevention: Rear facing/rear riding infant car seat □
Sleep on back □  Smoke detector/escape plan □  Hot water set at 120º □
Choking/suffocation □  Poison control # □  Fall prevention (heights) □
Hot liquids □  Firearms (owner risk/safe storage) □  Water safety (tub) □
Don’t leave unattended □

PLANS/ORDERS/REFERRALS
1. Immunizations ordered □ ___________________________
2. Second metabolic screen □ _________________________
3. Follow-up newborn hearing screen □ __________________
4. Next preventive appointment □ ______________________
5. Referrals for identified problems? (specify) ____________________________

Signatures: _____________________________________________________________________________________________________________

https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx

Maryland Healthy Kids Program 2018