PEDIATRIC VISIT 4 to 5 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: Child care:

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
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/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: Can add cereal; use spoon ☐ Iron in formula ☐
If breast fed, Vitamin D and iron ☐
Introduce single ingredient foods one at a time ☐

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Smiles ☐ Seeks eye contact with parent ☐

Fine Motor: Follows 180 degrees ☐ Grasps rattle ☐
Reaches for toy ☐ Hands together ☐

Language: Vocalizes ☐ Coos ☐ Laughs ☐

Gross Motor: Rolls over belly to back ☐ Lifts chest up ☐
Prone, lifts head 90 degrees ☐ Head steady when sitting ☐
Bears some weight on legs ☐

ANTICIPATORY GUIDANCE:

Social: Schedules/daily routines ☐ Sitter ☐

Parenting: Can't spoil ☐ Different babies have different temperaments ☐

Play and communication: Hanging toys ☐
Respond to baby's "conversation" ☐ Age appropriate toys ☐
Choose toys for shape, size and texture ☐

Health: Teething, drooling, chewing ☐ Clean teeth ☐
Second hand smoke ☐

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

PLANS/ORDERS/REFERRALS

1. Immunizations by schedule _____
2. Follow up newborn hearing screen _____
3. Next preventive appointment at 6 months ☐
4. Referrals for identified problems? *(specify)*

_____

_____

_____

_____

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_____

Signatures: _____