Well Child Visit: 1-2 Months

Name: ______________________ **DOB:** ______________ **Date:** ______________

Current Medications	Drug / Food Allergies	Accompanied By

Age ☐ M ☐ F	Ht.	Wt.	HC	HR	Resp.	Temp.	Interpreter: Y / N

Past Medical History

Gestational age: ______weeks

Birth weight:_______________

Newborn hearing screen: ☐ NL _________

Hep B vaccine: ___/____/_____

Recent illness: : ☐ Yes ☐ No ___________

Interval History

Sleep: ☐ NL____________________
☐ Back to sleep
☐ Sleeps in own crib

Elimination: ☐ NL _______________

Behavior: ☐ NL _________________

Car seat rear-facing: ☐ Yes ☐ No ____

Nutrition

☐ Breastfeeding ☐ Supplementing / both

☐ Formula (type): ________________

Frequency: _________________________

Water source: ___________ Vitamin: ______

Concerns:___________________________

Social / Family History

Lives at home with:_____________________________

Maternal depression: ☐ Yes ☐ No __________________

Parent / child interaction: ☐ Yes ☐ No _______________

Tobacco smoke exposure: ☐ Yes ☐ No_______________

Parents working outside home: ☐ Mother ☐ Father

Child Care: ☐ Yes ☐ No____________ Type: _________

WIC: ☐ Yes ☐ No _______________

Growth-Development

Cognitive: ☐ NL _______________
- Indicates boredom (crying/fussy) when no change in activity

Language: ☐ NL _______________
- Coos, different cries for different needs

Physical: ☐ NL _______________
- Able to hold head up, ↓newborn reflexes

Social: ☐ NL _______________
- Smiles, able to console/comfort self, looks toward parent

Parental concerns: ____

____

____

Physical Exam (checked ☐ = normal)

☐ **General** (Alert, NAD)
☐ **Head** (Fontanelle NL, symmetric)
☐ **Eyes** (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear)
☐ **Ears** (Canals clear, TMs normal, orients to sound, voice)
☐ **Nose** (Mucosa NL, septum NL, patent)
☐ **Mouth** (MMM, palate intact, lips NL, tongue/frenulum NL, no oral lesions)
☐ **Throat** (No erythema)
☐ **Heart** (No murmurs, + femoral pulses)
☐ **Lungs** (Clear breath sounds)
☐ **Abdomen** (Soft, non-tender)
☐ **Skin** (No rashes)
☐ **Neuro** (Tone, symmetry, strength all NL)
☐ **Extremities** (Full ROM, NL strength/tone, no Ortolani or Barlow sign, no torticollis)
☐ **Genitalia**
Male (Penis NL: circ/uncirc, no adhesions, testes ↓)
Female (No adhesions, labia/clitoris NL, no discharge)

Abnormal Findings

Assessment

☐ Well child
☐ Normal growth and development
☐ IMMS UTD
☐ IMMs due ______________________________
☐ TB testing based on risk factors (1 mos.)

Anticipatory Guidance

☐ **Family Transition** (Sleep when baby sleeps, baby blues, support network, importance of receiving postpartum care for mother)
☐ **Parent/Child interaction** (Play time, singing, bonding, routines)
☐ **Safety** (Back to sleep, car seats, avoid smoke exposure, crib safety, burns, smoke detectors, drowning, no shaking)
☐ **Nutrition** (Feeding cues, do not prop bottle, elimination, delay introducing solid foods, choking)
☐ **Development** (Milestones, tummy time, calming skills)

Plan

☐ Education handout given
☐ Immunizations (See immunization record)

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Name: ______________________________ **DOB:** ______________ **Date:** ________________

Next Appointment: ______________ **Signature:** ____________________________ **Date:** ___________

Notes:

Next Appointment: ______________ **Signature:** ____________________________ **Date:** ___________