



Well Child Visit: 5-6 Months



Name: _____ DOB: _____ Date: _____

Current Medications			Drug / Food Allergies			Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	HC	HR	Resp.	Temp.	Interpreter: Y / N	
Past Medical History			Interval History			Nutrition		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Reaction to previous IMMS: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ F/u previous concern: <input type="checkbox"/> None _____			Sleep: <input type="checkbox"/> NL _____ <input type="checkbox"/> Back to sleep <input type="checkbox"/> Sleeps in own crib Elimination: <input type="checkbox"/> NL _____ Behavior: <input type="checkbox"/> NL _____ Car seat rear-facing: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Supplementing / both <input type="checkbox"/> Formula (type): _____ Frequency: _____ Solids: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Vitamin: _____ Concerns: _____		
Social / Family History				Growth-Development				
Lives at home with: _____ Parent / child interaction: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Maternal Depression: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Parents working outside home: <input type="checkbox"/> Mother <input type="checkbox"/> Father Child care: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Family / work balance: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				Cognitive: <input type="checkbox"/> NL _____ • Beginning to use oral exploration for learning Language: <input type="checkbox"/> NL _____ • Strings vowels together, enjoys vocal turn taking Physical: <input type="checkbox"/> NL _____ • Rolling over & sitting; rocks back and forth; crawling backwards Social: <input type="checkbox"/> NL _____ • Interacts with parent and recognizes familiar faces				
Parental Concerns: _____ _____ _____								
Physical Exam (checked <input type="checkbox"/> = normal)						Abnormal Findings		
<input type="checkbox"/> General (Alert, NAD) <input type="checkbox"/> Head (Fontanelle NL, symmetric) <input type="checkbox"/> Eyes (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> Ears (Canals clear, TMs normal, orients to sound, voice) <input type="checkbox"/> Nose (Mucosa NL, septum NL, patent) <input type="checkbox"/> Mouth (MMM, palate intact, lips NL, tongue NL, no lesions) <input type="checkbox"/> Throat (No erythema)			<input type="checkbox"/> Heart (No murmurs, + femoral pulses) <input type="checkbox"/> Lungs (Clear breath sounds) <input type="checkbox"/> Abdomen (Soft, non-tender) <input type="checkbox"/> Skin (No rashes) <input type="checkbox"/> Neuro (Tone, symmetry, strength NL) <input type="checkbox"/> Extremities (Full ROM, NL strength/tone, no Ortolani or Barlow sign) <input type="checkbox"/> Genitalia <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (No adhesions, labia/clitoris NL, no discharge)					
Assessment				Anticipatory Guidance				
<input type="checkbox"/> Well child <input type="checkbox"/> Normal growth and development <input type="checkbox"/> IMMS UTD <input type="checkbox"/> IMMs due _____				<input type="checkbox"/> Safety (Back to sleep, car seats, avoid smoke exposure, crib safety, burns, baby-proof home, drowning, poisoning, baby gates) <input type="checkbox"/> Nutrition (Introducing pureed fruits and veggies, one new food at a time, watch for allergic reactions, continue breast feeding/formula) <input type="checkbox"/> Oral Health (Fluoride, wash gums with warm washcloth, teething) <input type="checkbox"/> Development (Milestones, vision development, communicating with baby-read, sing, imitate sounds, sleep, establish routines)				
Plan								
<input type="checkbox"/> Lead screening #1, if high risk (6 mos.) <input type="checkbox"/> Dental risk assessment (6 mos.) <input type="checkbox"/> Dental fluoride varnish every 3-6 mos. either primary care or dental office <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> TB testing based on risk factors (6 mos.) <input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Education handout given								

Next Appointment: _____ Signature: _____ Date: _____



Well Child Visit: 5-6 Months



Name: _____ DOB: _____ Date: _____

Notes:

Lined area for notes

Next Appointment: _____ Signature: _____ Date: _____