WELL CHILD VISIT – NEWBORN to 1 WEEK

☐ Male ☐ Female

Name: ______________________ ID # ______________ Age: _______ DOB: ____________ ☐ IHEBAT ☐ 120-Day IHA

Accompanied by: ☐ Mom ☐ Dad ☐ Relative ☐ Other: __________ **Date of Visit:**____________

Birth Wt:________ D/C Wt: ________ ______Weeks Gestation	Wt: lbs/oz/kg (%ile)	Ht: nches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Nurse/MA________________

HISTORY

Interim History:
- ☐ No Problems
  - ☐ Significant Illness / Injury ________________
  - ☐ Medications: ________________________
  - ☐ Allergies: ___________________________
  - ☐ Visits to other health care provider:
    (name) ____________________________________

Social / Family History:
- ☐ No problems
  - ☐ Divorced / Single Parent
  - ☐ Child Care: _________________________

Nutrition: ☐ Breast ☐ Bottle
Formula ____________ Oz/feed ___________
Hours between feeds ____________________
Feeding/24 hrs: ________________________
Vitamins:_____________________________

Elimination: ☐ NL ___________________________
____

Sleep: ☐ NL ____________________________
____

Behavior: ☐ NL __________________________

Toxic exposure: Lead ☐Yes ☐No Passive Smoking ☐Yes ☐ No
TB risk: ☐ High ☐ Low

PHYSICAL EXAM
(✓ if within Normal Limits)

NL — Comment if Abnormal

- ☐ General Appearance
- ☐ Skin
- ☐ Head
- ☐ Eyes / Appears to see
- ☐ Ears / Appears to hear
  - ☐ NL Hearing screening
- ☐ Nose
- ☐ Mouth and Throat
- ☐ Neck
- ☐ Lungs
- ☐ Heart
- ☐ Femoral pulses
- ☐ Abdomen
- ☐ Genitalia
- ☐ Ext/Hips
- ☐ Back
- ☐ Neurologic

ASSESSMENT

- ☐ Well Child

DEVELOPMENTAL HISTORY
(✓ if within Normal Limits)

- ☐ Responds to sound by startling, blinking, crying
- ☐ Blinks in reaction to bright light
- ☐ Looks at faces and follows with eyes
- ☐ Moves arms, legs and head
- ☐ Responds to parent's face and voice
- ☐ Can sleep for three or four hours at a time
- ☐ Has flexed posture

ANTICIPATORY GUIDANCE / EDUCATION
(✓ if discussed or handout given)

- ☐ Breastfeed or iron-fortified formula
- ☐ No honey, no cereal in bottle
- ☐ Delay solid food until 4-6 months
- ☐ Sleep on back, no bottle in bed
- ☐ Bathing and water temperature
- ☐ Cord, circumcision care
- ☐ Skin and nail care
- ☐ Sleep patterns, arrangements
- ☐ Console baby, hold, cuddle, rock, sing, talk to baby
- ☐ Car seat, smoke detectors
- ☐ Falls, keep hand on baby
- ☐ Pacifiers, thumb sucking
- ☐ Know signs of illness, thermometer use
- ☐ Family relationships & friends

REFERRALS / AUTHORIZATIONS

- ☐ WIC ☐ Vision Referral
- ☐ CCS
- ☐ Counseling
- ☐ Specialist (name) ____________________

IMMUNIZATIONS / LABORATORY

- ☐ Hepatitis B ☐ Hct/Hgb
- ☐ Other: ____________ ☐ ______________
- ☐ Vaccine Information Statements (VIS) given to patient

Plan: 1. **NEXT VISIT AT AGE 1 - 2 Months**
2.
3.

10/03

Signature________________________**MD/DO/NP/PA Date**:_________