# WELL CHILD VISIT - AGE 2 to 4 WEEKS

☐ 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: inches/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/day _____
Hours between feeds _____
Feedings/24 hrs _____
Vitamins _____

Elimination: ☐ NL _____
_____
Sleep: ☐ NL _____
_____
Behavior: ☐ NL _____

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

## DEVELOPMENTAL HISTORY
## (✓ if within Normal Limits)

- ☐ Raises head slightly in prone position
- ☐ Blinks in reaction to bright light
- ☐ Responds to sound by startling, blinking, crying
- ☐ Follows object to midline
- ☐ Responds to parent's face and voice
- ☐ Moves arms, legs and head
- ☐ Can sleep for three or four hours at a time
- ☐ When crying can be consoled most of time by being spoken to or held
- ☐ Coos, social smile

## 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

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

- ☐ Breast feed 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
- ☐ Skin and nail care
- ☐ Sleep patterns, arrangements
- ☐ Colic, console baby, hold, cuddle, rock, sing, talk to baby
- ☐ Car seat, smoke detectors
- ☐ Falls, small & sharp objects, plastic bags
- ☐ Pacifiers, thumb sucking
- ☐ No strings around neck, no shaking
- ☐ 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 2 Months**
2.
3.

10/03

**Signature**_____**MD/DO/NP/PA Date**:_____