WELL CHILD VISIT – AGE 4 MONTHS

☐ Male ☐ Female

Name: _____ ID # _____ Age: _____ DOB: _____ ☐ **IHEBAT** ☐ **120-Day IHA**

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

Wt: lbs/oz/kg (%ile)	Ht: inches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Hct/Hgb :_____ Nurse/MA_____

HISTORY

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

Social / Family History:
- ☐ No interval changes
  - ☐ Divorced / Single Parent
  - ☐ Child care Type:_____

Changes since last visit:_____

Nutrition: ☐ Breast ☐ Bottle
Formula _____ Oz/day _____
Feedings/24 hrs _____
Solid foods _____
Water _____ 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)

- ☐ Holds head erect
- ☐ Raises body on hands with head up
- ☐ Rolls front to back
- ☐ Reaches for and grabs objects
- ☐ Follows objects
- ☐ Babbles, coos, smiles, laughs and squeals
- ☐ Responds to sounds
- ☐ Blows bubbles, makes "raspberry sounds"
- ☐ Recognizes parent's voice and touch
- ☐ Open hands / holds own hands / grasps rattle

PHYSICAL EXAM (✓ if within Normal Limits)

NL		Comment if Abnormal
☐	General Appearance	
☐	Skin	
☐	Head	
☐	Eyes / Appears to see	
☐	Ears / Appears to hear	
☐	Nose	
☐	Mouth and Throat	
☐	Teeth	
☐	Neck	
☐	Lungs	
☐	Heart	
☐	Femoral Pulses	
☐	Abdomen	
☐	Genitalia	
☐	Ext/Hips	
☐	Back (Scoliosis)	
☐	Neurologic	

ASSESSMENT

- ☐ Well Child

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

- ☐ Breastfeeding, iron-fortified formula (supplement)
- ☐ Introduce solid foods, no honey
- ☐ Sleep on back, sleep arrangements
- ☐ Water temperature
- ☐ Bedtime routine
- ☐ Hold, cuddle, rock
- ☐ No baby walkers
- ☐ Car seats, smoke detectors
- ☐ Games, toys, comfort objects
- ☐ Talk, sing, play music
- ☐ Know signs of illness
- ☐ Childproof home; Syrup of Ipecac
- ☐ Sunscreen
- ☐ Injury prevention, falls, choking, burns, guns

REFERRALS / AUTHORIZATIONS

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

IMMUNIZATIONS / LABORATORY

- ☐ DTaP ☐ IPV ☐ PCV ☐ Hct/Hgb
- ☐ Hib ☐ Hep B
- ☐ Other: _____ ☐ _____
- ☐ Vaccine Information Statements (VIS) given to patient

Plan: 1. **NEXT VISIT AT AGE 6 Months**
2.
3.

10/03

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