

<b>WELL CHILD - Under 1 month</b>				Name: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male			
Visit Date: ___/___/___				DOB: ___/___/___ Age: _____			
Language: <input type="checkbox"/> English Other: _____ <input type="checkbox"/> Interpreter used – Name: _____							
T: _____	P: _____	RR: _____	H.C. _____	Length: _____	Weight: lb. oz.	Birth Weight: lb. oz.	<input type="checkbox"/> Growth charts completed
Reason for visit: <input type="checkbox"/> well visit							
Allergies: _____				Signature/ Title: _____			

<b>BIRTH HISTORY – G:</b> P: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean				<b>GROWTH and DEVELOPMENT</b>			
Pregnancy/delivery complications: _____				<input type="checkbox"/> Prone, lifts head briefly		<input type="checkbox"/> Blinks at bright light	
				<input type="checkbox"/> Moro reflex		<input type="checkbox"/> Responds to sound	
APGARS – 1: 5: TB risk: <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> Turns head side to side			
Diet: <input type="checkbox"/> breast <input type="checkbox"/> formula WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>EDUCATION / ANTICIPATORY GUIDANCE: Check if discussed</b>			
Elimination: _____				<b>Diet</b>		<input type="checkbox"/> burping <input type="checkbox"/> bottle propping <input type="checkbox"/> weight loss/gain	
Sleep – position: _____ patterns: _____						<input type="checkbox"/> breast vs. formula feeding <input type="checkbox"/> stools	
Mother getting adequate sleep: <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>Safety</b>		<input type="checkbox"/> car seat <input type="checkbox"/> sleeping positions <input type="checkbox"/> crib safety	
<input type="checkbox"/> Exposure to tobacco smoke						<input type="checkbox"/> fall prevention <input type="checkbox"/> smoke exposure	
<b>PARENTAL CONCERNS:</b>				<b>Guidance</b>		<input type="checkbox"/> postpartum depression <input type="checkbox"/> bathing/skin care	
						<input type="checkbox"/> cord care <input type="checkbox"/> circ/foreskin care <input type="checkbox"/> fever	
						<input type="checkbox"/> family dynamics	

<b>PHYSICAL EXAMINATION – note required for all not WNL</b>							
<b>General Appearance</b>		<input type="checkbox"/> well nourished and developed		<b>Femoral pulses</b>		<input type="checkbox"/> normal bilaterally	
		<input type="checkbox"/> no abuse/neglect evident		<b>Abdomen</b>		<input type="checkbox"/> soft, no masses <input type="checkbox"/> liver & spleen normal	
<b>Head</b>		<input type="checkbox"/> symmetrical <input type="checkbox"/> AF open _____ cm		<b>Genitalia</b>		<input type="checkbox"/> grossly normal	
<b>Eyes</b>		<input type="checkbox"/> appears to see <input type="checkbox"/> red reflex = bilaterally		<i>male:</i>		<input type="checkbox"/> circumcised <input type="checkbox"/> testes in scrotum L R	
<b>Ears</b>		<input type="checkbox"/> canals clear <input type="checkbox"/> TMs normal		<b>Spine</b>		<input type="checkbox"/> normal, no sacral dimple	
		<input type="checkbox"/> appears to hear		<b>Extremities</b>		<input type="checkbox"/> no deformities, full ROM	
<b>Nose/ mouth</b>		<input type="checkbox"/> patent <input type="checkbox"/> MM pink, no lesions		<b>Hips</b>		<input type="checkbox"/> good abduction, no clicks	
<b>Neck</b>		<input type="checkbox"/> supple / no masses		<b>Skin</b>		<input type="checkbox"/> clear, no significant lesions	
<b>Lungs</b>		<input type="checkbox"/> clear to auscultation bilaterally		<b>Neurologic</b>		<input type="checkbox"/> normal tone <input type="checkbox"/> symmetrical movements	
<b>Heart</b>		<input type="checkbox"/> regular rhythm <input type="checkbox"/> no murmur					

**Comments:** \_\_\_\_\_

\_\_\_\_\_

<b>ASSESSMENT:</b>	<b>PLAN:</b>

**ORDERS:**  Vaccine reactions, risks and follow-up explained /VIS sheets given  Immunization registry entry

Hep B

Obtain newborn hospital records and newborn screen results

Other: \_\_\_\_\_

**REFERRAL:**  WIC Other: \_\_\_\_\_  PM 160 completed

**Next appointment:**  1 month Other: \_\_\_\_\_ **Provider Signature:** \_\_\_\_\_