WELL CHILD -2 to 3 months

Name: ☐ Female ☐ Male

Visit Date: ___/____/____ DOB: ____/____/____ Age: __________

Language: ☐ English Other: ☐ Interpreter used – Name:

T:	P:	RR:	H.C.	Length: in.	Weight: lb.	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies: **Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ breast ☐ formula **WIC:** ☐ Yes ☐ No

Appetite: **TB risk:** ☐ No ☐ Yes

Elimination:

Sleep – position: amount:

Illnesses:

Mother getting adequate sleep: ☐ Yes ☐ No

Childcare:

PARENTAL CONCERNS

GROWTH and DEVELOPMENT

☐ Prone, lifts head 45°	☐ Rolls side to side	☐ Kicks
☐ Smiles responsively	☐ Orients to voices	☐ Grasps
☐ Follows past midline	☐ Brings hands together	☐ Vocalizes

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet	☐ burping ☐ feeding position ☐ weight loss/gain ☐ breast feeding support ☐ no milk / honey until 1 yr.
Safety	☐ car seat ☐ sleeping positions ☐ crib safety ☐ fall prevention ☐ smoke exposure ☐ sun screen
Guidance	☐ postpartum depression ☐ bathing/skin care ☐ circ/foreskin care ☐ fever ☐ family dynamics ☐ bedtime/sleep patterns ☐ spoiling

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Femoral pulses**	☐ normal bilaterally
		Abdomen	☐ soft, no masses ☐ liver & spleen normal
Head	☐ symmetrical ☐ AF open ______ cm	**Genitalia**	☐ grossly normal
Eyes	☐ appears to see ☐ red reflex = bilaterally	*male:*	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal	**Spine**	☐ normal, no sacral dimple
	☐ appears to hear	**Extremities**	☐ no deformities, full ROM
Nose/ mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction, no clicks
Neck	☐ supple / no masses	**Skin**	☐ clear, no significant lesions
Lungs	☐ clear to auscultation bilaterally	**Neurologic**	☐ normal tone ☐ normal DTR's
Heart	☐ regular rhythm ☐ no murmur		

Comments:

ASSESSMENT: **PLAN:**

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

Immunization: ☐ DTaP ☐ Hep B ☐ Hib ☐ IPV ☐ Prevnar ☐ Rotavirus

REFERRAL: ☐ WIC Other: ____ ☐ PM 160 completed

Next appointment: ☐ 2 months Other: _________________________ **Provider Signature:** _______________________