PEDIATRIC VISIT 0 to 1 MONTH

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**
Maternal Depression? Yes / No
Support?

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

Risk Assessment: TB Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin/Umbilicus
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐
Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐
Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐
Sneezing, hiccoughs, soft spot ☐
Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐
Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120º ☐
Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐
Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐
Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen ☐ _____
3. Follow-up newborn hearing screen ☐ _____
4. Next preventive appointment ☐ _____
5. Referrals for identified problems? *(specify)*_____

_____
_____
_____
_____
_____
_____
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_____

Signatures: _____