WELL CHILD VISIT CHECKLIST
4 month

Child Name: _____DOB: _____ Ctr./CR: _____

Physical Exam Date:_____ Milestone Age:_____

Next Possible Well Child Appointment *(Month/Year)*: **_____**

	Done	Not Done	Comments
Health History			
Height			
Weight			
Head Circumference			
Vision (subjective)			
Hearing (subjective)			
Dev./Behavioral Assessment			
Physical Examination			
Immunizations			
Anticipatory Guidance ***-Injury prevention*** ***-Violence prevention*** ***-Sleep positioning counseling*** ***-Nutrition counseling***			