D.C. DEPARTMENT OF HEALTH Health Check MEDICAL ASSISTANCE ADMINISTRATION

WELL CHILD/2 to 4 MONTHS

MR #: _____

NAME	DOB	❑ M ❑ F	DRUG ALLERGIES	❑ 1st Visit ❑ Periodic Visit

DATE/TIME	INSURANCE ID #	AGE YRS MOS	WEIGHT ❑ lb. ❑ kg. %	HEIGHT ❑ in. ❑ cm. %	HEAD CIRC. ❑ in. ❑ cm. %

ACCOMPANIED BY	PHONE 1	PHONE 2	IF INDICATED:	PULSE Ox	TEMP	RR	P	BP

History/Parent Concerns

Interval History: ❑ None ❑ Newborn History Previously Taken

_____

_____

Current Medications: _____

_____

Social/Family History

❑ Completed _____

_____

_____

_____

Child Care: ❑ Yes ❑ No Type: _____

Review of Systems

❑ Nutrition Assessed: ❑ Breastfed ❑ Formula _____

_____

❑ Elimination Assessed _____

❑ Environment Assessed _____

❑ Sleep Patterns Assessed _____

❑ Development Assessed: (Use Table on Back) _____

OR ❑ DENVER DEVEL. II ADMINISTERED

OR ❑ OTHER TOOL ADMINISTERED: _____

Comments: _____

_____

_____

_____

Anticipatory Guidance Provided

❑ Topics discussed and/or handout given

SUGGESTED AGE APPROPRIATE TOPICS ARE ON THE BACK

Immunizations/Screens

Newborn Metabolic Screen: ❑ Pending ❑ NL ❑ ABN _____

Newborn Hearing Screening: ❑ Pending ❑ Pass ❑ Fail

❑ Immunizations Reviewed

Immunizations Ordered:

❑ DTaP ❑ IPV ❑ HIB ❑ HBV

❑ HIB/HBV ❑ DTAP/IPV/HBV ❑ PCV7 ❑ Rotavirus

❑ Medical / Religious Exemptions: _____

Immunization Comments: _____

_____

Physical Examination (Unclothed)

NL ABN

❑ ❑ General Appearance _____

❑ ❑ Head / Fontanelle _____

❑ ❑ Eyes / Red Reflex _____

❑ ❑ Ears _____

❑ ❑ Nose _____

❑ ❑ Mouth/Throat _____

❑ ❑ Lungs _____

❑ ❑ Heart / Pulses _____

❑ ❑ Abdomen _____

❑ ❑ Genitalia _____

❑ ❑ Extremities / Hips _____

❑ ❑ Back _____

❑ ❑ Skin _____

❑ ❑ Neurologic _____

_____

Assessment and Plan

❑ Well Child ❑ Additional concerns or identified special health needs (detail below):

❑ Hearing Concern ❑ Prematurity ❑ Dev Delay ❑ Seizure(s) ❑ Wheezing/RAD

❑ Other:

Assessment: _____

_____

_____

_____

Plan: _____

_____

_____

_____

_____

❑ **Education handouts and/or plan reviewed with patient/parent, who verbalizes understanding**

Referrals

❑ Referral Made: _____

F/U Next Visit: _____

History and physical reviewed with resident at time of visit, agree with the diagnosis of and treatment

Provider	Print	Signature
Nurse	Print	Signature
Other	Print	Signature

Version 1.1 (5/06)

 Instructions: If the action was taken or completed, the open box must be marked (☑ or ☒).

ADDITIONAL COMMENTS: _____

NURSING NOTES: PAIN? ❑ No ❑ Yes [ ] Score _____

❑ Management: See Treatment Plan

Interpreter Used? ❑ Yes ❑ No Primary Language:_____

BEHAVIOR AND DEVELOPMENT				
Age	**Gross Motor**	**Fine Motor**	**Communication**	**Social**
2 Months	__ Lifts head when prone (45 degrees)	__ Follows object to midline	__ Coos (ooh/aah) __ Responds to sounds	__ Social smiles (spontaneously)
4 Months	__ Pulls to sit __ Raise body when prone __ Roll front to back __ Sit head steady __ Bear weight	__ Grasps objects __ Bring hands together __ Follows objects 180 degrees	__ Laughs/squeals	__ Regards hands

Suggested age appropriate topics for anticipatory guidance:

■ NUTRITION
- Breastfeeding
- Vitamins
- Formula
- No solid food until 4-6 mos
- No honey/juice
- Elimination
- Review of WIC status

At 4 months:
- May start rice cereal
- Introduce only 1 solid food every week

■ ORAL HEALTH
- No bottle in crib

■ IMMUNIZATIONS EXPLAINED

■ INFANT CARE
- Skincare
- Thermometer training
- Good sleep habits

■ BEHAVIOR & DEVELOPMENT

■ PARENT-INFANT INTERACTION
- Temperament
- Parental depression
- Sibling rivalry
- Family relationships
- Establish routines
- Talk/read/sing to baby
- Hold/cuddle/play

■ INJURY AND ILLNESS PREVENTION
- Crib safety
- Back to sleep
- Child safety seat
- Falls
- Burns
- Water heater
- Smoke detectors
- Sun safety
- Violence/guns
- Passive smoking
- Lead risks (≥ 10 ug/dL, high risk)
- Never shake baby