CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

SIGNIFICANT NEONATAL HX	**DOB** *(YYYYMMDD)*	**WEIGHT**	**HEIGHT**	**PKU**

DATE OF VISIT *(YYYYMMDD)*		
AGE		
WEIGHT		
HEIGHT		
HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY)		
1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 2. ELIMINATION 3. GROWTH AND DEVELOPMENT 4. PARENTAL CONCERNS		
OBJECTIVE PHYSICAL EXAM		
NUTRITION		
HEAD/FONTANEL		
EENT		
NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING		
SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT *(YYYYMMDD)*		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS

SIGNIFICANT NEONATAL HX	DOB *(YYYYMMDD)*	WEIGHT	HEIGHT	PKU

DATE OF VISIT *(YYYYMMDD)*		
AGE		
WEIGHT		
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HEAD CIRCUMFERENCE		
SUBJECTIVE (HISTORY) 1. FEEDING 2. FORMULA/BREAST SOLIDS VITAMINS/FLOURIDE 2. ELIMINATION 3. GROWTH AND DEVELOPMENT 4. PARENTAL CONCERNS		
OBJECTIVE **PHYSICAL EXAM**		
NUTRITION		
HEAD/FONTANEL		
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NECK/CLAVICLES		
LUNGS		
HEART		
ABDOMEN		
GENITALIA/HERNIA		
HIPS/SPINE		
EXTREMITIES		
SKIN		
NEUROLOGICAL		
ASSESSMENT		
PLANS AND COUNSELING SAFETY FEEDING GROWTH AND DEVELOPMENT IMMUNIZATION NEXT VISIT*(YYYYMMDD)*		
	EXAMINED BY	EXAMINED BY

PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility)	REMARKS