FLORIDA DEPARTMENT OF HEALTH

4 - 6 Month Child Health History & Physical Check-up

PLEASE PRINT

PERSONAL: ☐ **Well child visit** ☐ **Parent/Caregiver Request**

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP

PRENATAL HISTORY: ☐ **Completed previously**

FIRST PRENATAL VISIT DATE		ALCOHOL, AMOUNT		TOBACCO or 2ND HAND SMOKE EXPOSURE, AMOUNT	STREET DRUGS: AMOUNT
STDs (specify)	GROUP B STREP	HEPATITIS B	HIV	☐ POST PARTUM DEPRESSION OTHER MATERNAL PROBLEMS:	PRESCRIBED MEDS
WEEKS GESTATION		☐ VAGINAL DELIVERY ☐ CAESAREAN DELIVERY		BIRTH WEIGHT	WHERE DELIVERED

PERINATAL HISTORY: ☐ **Completed previously**

PROBLEMS:	OTHER	DATE OF Discharge:

MEDICAL HISTORY: (any changes or concerns since last visit) ☐ NO ☐ YES (DESCRIBE)

FAMILY MEDICAL HISTORY **(any changes or concerns since last visit)** ☐ NO ☐ YES (DESCRIBE)

ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS: ☐ NO ☐ YES (DESCRIBE)

DEVELOPMENTAL ISSUES ☐ NO ☐ YES (DESCRIBE)

BEHAVIORAL ISSUES ☐ NO ☐ YES (DESCRIBE)

CURRENT MEDS: ☐ VITAMINS ☐ IRON

DEVELOPMENTAL ASSESSMENT:

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (Does this client roll over from prone position, reach for, grasp and put objects in mouth, laughs, squeals by 4 mos.; sit with no support, crawl, transfer objects between hands by 6 mos)

☐ YES ☐ NO ☐ REFERRED Formalized Screening tool_____ Results_____

NUTRITIONAL ASSESSMENT

Is this a WIC participant? ☐Yes ☐No ☐Referred

Is your home on: ☐ well water ☐city water | If on city water, is it fluoridated? ☐ YES ☐ NO ☐ DON'T KNOW

Breast milk ☐ Exclusively ☐ Partially	**# Of Wet Diapers/ Day**	**# Of Soiled Diapers/ Day**	**Consistency** ☐ LIQUID ☐ SEEDY ☐ SOFTLY FORMED ☐ HARD FORMED	☐**FORMULA**:_____ **Amount per feeding:** **/Frequency:**	**Diet Adequate?** ☐Yes ☐No
Frequency: **Length of feedings:**		**Stool Color**			

What other beverages does this child drink? (check all that apply):

☐ soy milk ☐ Whole milk ☐ 2% reduced fat milk ☐ 1% low fat milk ☐ fat free milk
☐ Water ☐ 100% fruit juice ☐ Gatorade ☐ Fruit drinks ☐ soda
☐ tea ☐ water with sugar ☐Bottled Water

Nutrition supplements _____ ☐ other _____

Signature/Title_____ Date_____

Signature/Title_____ Date_____

Label

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PHYSICAL EXAM

TEMP: PULSE: RESPIRATIONS:	LENGTH:	WEIGHT:	HEAD CIRCUMFERENCE:	CHEST CIRCUMFERENCE:
Type:	Percentile:	Percentile:	Percentile:	Percentile:

Check as appropriate √	N	A	N=Normal A=Abnormal COMMENTS
1. Appearance			
2. Skin			
3. Head			
4. Eyes			
5. Ears			
6. Nose			
7. Mouth/Throat			
8. Teeth/Gums			
9. Nodes			
10. Heart			
11. Lungs			
12. Abdomen/Umbilicus			
13. Femoral Pulse			
14. External Genitalia			
15. Hip Exam			
16. Extremities			
17. Spine			
18. Neurological			
19. Other			

LAB TESTS: ☐ **Previously Screened**

☐ LEAD RISK ASSESSMENT (@ 1 mo.-6 yrs.; if positive do blood screen)	☐ OTHER (Specify, as indicated)

SENSORY SCREEN:

VISION: (red reflex, Cover-uncover, follows)	HEARING: (i.e., Responds to sound, repeats sounds)
☐ NORMAL ☐ ABNORMAL ☐ REFERRED	☐ NORMAL ☐ ABNORMAL ☐ REFERRED

IMMUNIZATIONS PLAN: DUE TODAY_____ ☐ ADMINISTERED ☐ DEFERRED/PARENT DECLINED ☐ NONE DUE

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

☐ INFANT CAR SEAT	☐ "BACK TO SLEEP"	☐ CRIB/ BASSINETTE	☐ NUTRITION/FEEDING	☐ FIREARMS IN HOME
☐ DAYCARE	☐ DENTAL HYGIENE	☐ SUN PROTECTION	☐ DOMESTIC VIOLENCE	☐ 2ND HAND SMOKE
☐ SKIN CARE	☐ NO BOTTLE IN BED	☐ CHOKING, ASPIRATION	☐ READ TO BABY	☐ SOLID FOODS
☐ PETS IN HOME	☐ FEVER EDUCATION	☐ POISONS	☐ TEETHING	☐ LEAD EXPOSURE
☐ SAFETY/ FALLS -Rolling Over		☐ POST PARTUM DEPRESSION	☐ SHAKEN BABY SYNDROME	
☐ OTHER _____		☐ LITERATURE GIVEN _____		

ASSESSMENT/DIAGNOSIS:	**PLAN/ORDERS/REFERRAL:**

RETURN APPT:	ORDERS REVIEWED BY:

Signature/Title_____ Date_____

Signature/Title_____ Date_____

Label

DH 3105H, 09/08 (Replaces DH 3105A & DH 3105B)

4 Month up to 6 Month Child Health History & Physical

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