



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 2 ND HAND SMOKE EXPOSURE, AMOUNT	STREET DRUGS: AMOUNT
STDs (specify)	GROUP B STREP	HEPATITIS B	HIV
		<input type="checkbox"/> POST PARTUM DEPRESSION	PRESCRIBED MEDS
		OTHER MATERNAL PROBLEMS:	
WEEKS GESTATION	<input type="checkbox"/> VAGINAL DELIVERY <input type="checkbox"/> 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)

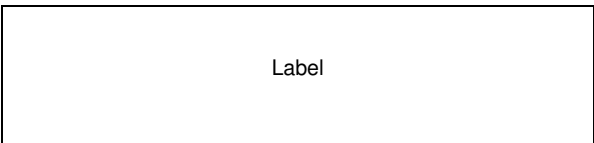
YES NO REFERRED Formalized Screening tool _____ Results _____

NUTRITIONAL ASSESSMENT

Is this a WIC participant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred				
Is your home on: <input type="checkbox"/> well water <input type="checkbox"/> city water		If on city water, is it fluoridated? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW		
Breast milk <input type="checkbox"/> Exclusively <input type="checkbox"/> Partially	# Of Wet Diapers/ Day	# Of Soiled Diapers/ Day	Consistency <input type="checkbox"/> LIQUID <input type="checkbox"/> SEEDY <input type="checkbox"/> SOFTLY FORMED <input type="checkbox"/> HARD FORMED	<input type="checkbox"/> FORMULA: _____ Amount per feeding: /Frequency:
Frequency: Length of feedings:	Stool Color			Diet Adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No
What other beverages does this child drink? (check all that apply):				
<input type="checkbox"/> soy milk	<input type="checkbox"/> Whole milk	<input type="checkbox"/> 2% reduced fat milk	<input type="checkbox"/> 1% low fat milk	<input type="checkbox"/> fat free milk
<input type="checkbox"/> Water	<input type="checkbox"/> 100% fruit juice	<input type="checkbox"/> Gatorade	<input type="checkbox"/> Fruit drinks	<input type="checkbox"/> soda
<input type="checkbox"/> tea	<input type="checkbox"/> water with sugar	<input type="checkbox"/> Bottled Water		
Nutrition supplements _____			<input type="checkbox"/> other _____	

Signature/Title _____ Date _____

Signature/Title _____ Date _____





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

PLEASE PRINT

PHYSICAL EXAM

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

Check as appropriate <input type="checkbox"/>	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

<input type="checkbox"/> LEAD RISK ASSESSMENT (@ 1 mo.-6 yrs.; if positive do blood screen)	<input type="checkbox"/> OTHER (Specify, as indicated)
---	--

SENSORY SCREEN:

VISION: (red reflex, Cover-uncover, follows) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED	HEARING: (i.e., Responds to sound, repeats sounds) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED
---	---

IMMUNIZATIONS PLAN: DUE TODAY _____ ADMINISTERED DEFERRED/PARENT DECLINED NONE DUE

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

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

ASSESSMENT/DIAGNOSIS:	PLAN/ORDERS/REFERRAL:
------------------------------	------------------------------

RETURN APPT: _____	ORDERS REVIEWED BY: _____
--------------------	---------------------------

Signature/Title _____ Date _____

Signature/Title _____ Date _____

Label



4 Month up to 6 Month Child Health History & Physical
PLEASE PRINT

Signature/Title _____ Date _____

Signature/Title _____ Date _____

Label
