



WELL CHILD / 2 to 4 MONTHS

DRUG ALLERGIES		<input type="checkbox"/> 1st Visit <input type="checkbox"/> Periodic Visit		DATE/TIME		INSURANCE ID #	
WEIGHT %		HEIGHT %		HEAD CIRC. %		NAME	
PULSE O _x		TEMP		BP		RR	
P		ACCOMPANIED BY		PHONE 1		PHONE 2	

History/Parent Concerns **Physical Examination (Unclothed)**

Interval History: None Newborn History Previously Taken

Current Medications: _____

NL ABN

General Appearance _____

Head / Fontanelle _____

Eyes / Red Reflex _____

Ears _____

Nose _____

Mouth/Throat _____

Lungs _____

Heart / Pulses _____

Abdomen _____

Genitalia _____

Extremities / Hips _____

Back _____

Skin _____

Neurologic _____

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: _____

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: _____

Anticipatory Guidance Provided

Topics discussed and/or handout given

SUGGESTED AGE APPROPRIATE TOPICS ARE ON THE BACK

Referrals

Referral Made: _____

F/U Next Visit: _____

Immunizations / Screens

Newborn Metabolic Screen: Pending NL ABN _____

Newborn Hearing Screen: Pending Pass Fail _____

Immunizations Reviewed

Immunizations Ordered:

DTaP IPV HIB HBV

HIB/HBV DTAP / IPV / HBV PCV7

Medical / Religious Exemptions: _____

Immunization Comments: _____

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

Provider	Print	Signature
NP/PA Trainee	Print	Signature
Nurse	Print	Signature

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

ADDITIONAL COMMENTS: _____

NURSING NOTES: _____

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

Suggested age appropriate topics for anticipatory guidance:

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> ■ NUTRITION <ul style="list-style-type: none"> ▪ Breastfeeding ▪ Vitamins ▪ Formula ▪ No solid food until 4-6 mos ▪ No honey / juice ▪ Elimination ▪ Review of WIC status At 4 months: <ul style="list-style-type: none"> ▪ May start rice cereal ▪ Introduce only 1 solid food every week ■ ORAL HEALTH <ul style="list-style-type: none"> ▪ No bottle in crib ■ IMMUNIZATIONS EXPLAINED | <ul style="list-style-type: none"> ■ INFANT CARE <ul style="list-style-type: none"> ▪ Skincare ▪ Thermometer training ▪ Good sleep habits ■ BEHAVIOR & DEVELOPMENT ■ PARENT-INFANT INTERACTION <ul style="list-style-type: none"> ▪ Temperament ▪ Parental depression ▪ Sibling rivalry ▪ Family relationships ▪ Establish routines ▪ Talk/read/sing to baby ▪ Hold/cuddle/play | <ul style="list-style-type: none"> ■ INJURY AND ILLNESS PREVENTION <ul style="list-style-type: none"> ▪ 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 |
|---|--|---|

INSTRUCTIONS

If the action was taken or completed, the open box must be marked (or .

If the child is enrolled in Medicaid, please be sure to print and sign your name in the space provided and fax or mail the completed form to:

**HEALTHCHECK REGISTRY
 POST OFFICE BOX 77498
 WASHINGTON, DC 20013-7749
 FAX: (202) 541-5907**

For further information on HealthCheck or Bright Futures go to www.brightfutures.org/healthcheck.html