**PEDIATRIC VISIT 0 to 1 MONTH** DATE OF SERVICE

NAME M / F DATE OF BIRTH AGE

WEIGHT / % HEIGHT / % HC / % TEMP

# HISTORY:

Family health history documented & updated? Perinatal history documented & updated? Concerns:

# PSYCHOSOCIAL ASSESSMENT:

## Sleep: Child care:

**Maternal Depression Screen?** Yes / No

**Referral or Support? Yes/No** (circle)

**Recent changes in family:** *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other

**Environment:** Smokers in home? Yes / No

## Violence Assessment:

History of injuries, accidents? Yes / No Evidence of neglect or abuse? Yes / No

**Risk Assessment: TB** Positive or Negative (circle)

## PHYSICAL EXAMINATION (unclothed)

Wnl Abn *(describe abnormalities)*

**** **** Appearance/Interaction

**** **** Growth

**** **** Skin/Umbilicus

**** **** Head/Face/Fontanelles

**** **** Eyes/Red reflex/Cover test

**** **** Ears

**** **** Nose

**** **** Mouth/Gums

# NUTRITIONAL ASSESSMENT:

**Breast/bottle:** Amount & frequency

**Bowel/bladder:** Number of wet , dry in 24 hours? Number BM's in 24 hours?

**Education:** Hold to feed **** Use of pacifier ****

If breast fed, Vitamin D **** Feed on demand **** Growth spurts ****

**DEVELOPMENTAL SURVEILLANCE:** *(****O****bserved or* ***R****eported)*

**Social:** Regards face **** Alert **** Social smile **** **Fine Motor:** Follows 90 degrees **** Grasps **** **Language:** Coos **** Laughs ****

**Gross Motor:** Head steady when sitting **** Hand brought to mouth ****

# ANTICIPATORY GUIDANCE:

**Social:** Time out for parent **** Parental adjustment ****

Sibling rivalry ****

**Parenting:** Respond to cry **** Trust-building **** Holding, comfort ****

**Play and communication:** Crying is communication ****

Voices, mobiles, music, pictures ****

**Health:** Diaper/skin care **** Bathing & washing hair ****

Sneezing, hiccoughs, soft spot ****

Taking baby's temperature **** Second hand smoke ****

**Injury prevention:** Rear facing/rear riding infant car seat ****

Sleep on back **** Smoke detector/escape plan **** Hot water set at 120º ****

 Choking/suffocation **** Poison control # **** Fall prevention (heights) ****

**** **** Neck/Nodes

**** **** Lungs

**** **** Heart/Pulses

**** **** Chest/Breasts

**** ****

Hot liquids **** Firearms (owner risk/safe storage) **** Water safety (tub) ****

Don’t leave unattended ****

# PLANS/ORDERS/REFERRALS

1. Immunizations ordered ****
2. Second metabolic screen ****

Abdomen

**** **** Genitals/Circumcision

1. Follow-up newborn hearing screen ****

 4. Next preventive appointment ****

**** **** Extremities/Hips/Feet

5. Referrals for identified problems? *(specify)*

**** **** Neuro/Reflexes/Tone

**** **** Vision *(gross assessment)*

**** **** Hearing *(gross assessment)*

Signatures:

https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx ***Maryland Healthy Kids Program*** 2020