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
		______________________________
☐	☐	Neck/Nodes
☐	☐	Lungs
		______________________________
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		______________________________
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		______________________________
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		______________________________
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

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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: *(Observed or Reported)*

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) ☐ Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ ______________________________
2. Second metabolic screen ☐ ____________________________
3. Follow-up newborn hearing screen ☐ ______________________
4. Next preventive appointment ☐ ___________________________
5. Referrals for identified problems? *(specify)*__________________

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Signatures: ____