**PEDIATRIC VISIT 2 to 3 MONTHS** 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? Yes / No**

**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** Circle: **Positive / Negative (**if not done at one month visit)

## PHYSICAL EXAMINATION(unclothed)

Wnl Abn *(describe abnormalities)*

**** **** Appearance/Interaction

**** **** Growth

**** **** Skin

**** **** Head/Face/Fontanelles

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

**** **** Ears

**** **** Nose

**** **** Mouth/Gums/Dentition

**** **** Neck/Nodes

**** **** Lungs

**** **** Heart/Pulses

**** **** Chest/Breasts

**** **** Abdomen

**** **** Genitals

**** **** Extremities/Hips/Feet

# 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 **** Avoid solid foods until 4-6 months ****

**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 ****

Father’s involvement ****

**Parenting:** Comfort often **** Infant developing trust ****

Holding much of time when awake ****

Temperaments differ among infants ****

**Play and communication:** Infant seat **** Mobiles, music, pictures ****

Talk or sing to baby **** Objects to kick or bat at ****

**Health:** Fever/taking temp **** Rashes **** Diarrhea ****

Second hand smoke ****

**Injury prevention:** Rear riding/rear facing infant car seat **** Smoke detector/escape plan **** Hot liquids **** Poison control # **** Hot water set at 120º **** Water safety (tub/pool) **** Choking/suffocation **** Firearms (owner risk/safe storage) ****

Fall prevention (heights) **** Don’t leave unattended ****

# PLANS/ORDERS/REFERRALS

1. Immunizations ordered ****
2. Second metabolic screen, if not done earlier ****
3. Follow up newborn hearing screen ****
4. Next preventive appointment at 4 months ****
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