## 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 (Annual)**

### PHYSICAL EXAMINATION

| 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 |
| ☐ | ☐ | Neuro/Reflexes/Tone |
| ☐ | ☐ | Vision *(gross assessment)* |
| ☐ | ☐ | Hearing *(gross assessment)* |

______________________________________

______________________________________

### 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: *(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 ☐
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)*

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

Signatures: ______________________________________________________________