**PEDIATRIC VISIT 3 to 5 DAY** DATE OF SERVICE

NAME M / F DATE OF BIRTH AGE

WEIGHT / % HEIGHT / % HC / % TEMP

# HISTORY:

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

# PSYCHOSOCIAL ASSESSMENT:

## Sleep: Child care:

**Maternal Depression Screen?** Yes / No

## Support?

**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

**PHYSICAL EXAMINATION (unclothed)**

# 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 ****

# 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 ****

|  |  |  |
| --- | --- | --- |
| Wnl | Abn | *(describe abnormalities)* |
| **** | **** | Appearance/Interaction |
| **** | **** | Growth |
|  |  |  |

**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) ****

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **** | **** | Skin/Umbilicus |  | Hot liquids **** Firearms (owner risk/safe storage) **** Water safety (tub) ****  Don’t leave unattended **** |
| ****  ****  ****  ****  ****  ****  **** | ****  ****  ****  ****  ****  ****  **** | Head/Face/Fontanelles Eyes/Red reflex/Cover test Ears  Nose Mouth/Gums    Neck/Nodes Lungs |  | **PLANS/ORDERS/REFERRALS**   1. Immunizations ordered **** 2. Follow-up newborn hearing screen **** 3. Next preventive appointment **** 4. Referrals for identified problems? *(specify)* |
|  |  |  |  |  |
| ****  **** | ****  **** | Heart/Pulses Chest/Breasts |  |  |
|  |  |  |  |  |
| ****  **** | ****  **** | Abdomen Genitals/Circumcision |  |  |
|  |  |  |  |  |
| ****  **** | ****  **** | Extremities/Hips/Feet Neuro/Reflexes/Tone |  |  |
|  |  |  |  |  |
| ****  **** | ****  **** | Vision *(gross assessment)*  Hearing *(gross assessment)* |  |  |

Signatures:

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