# 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? 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

Risk Assessment: TB Circle Positive/Negative (Annual)

## PHYSICAL EXAMINATION

| 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)* |

_______________________________________________

## 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 ☐

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. Follow-up newborn hearing screen ☐ ____________________
3. Next preventive appointment ☐ _________________________
4. Referrals for identified problems? *(specify)*________________

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Signatures: ______________________________________________________________