**PEDIATRIC VISIT 4 to 5 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? Reactions to immunizations? Yes / No Concerns:

# PSYCHOSOCIAL ASSESSMENT:

## Sleep: Child care:

**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 prior)

## PHYSICAL EXAMINATION(unclothed)

Wnl Abn *(describe abnormalities)*

**** **** Appearance/Interaction

**** **** Growth

**** **** Skin

# NUTRITIONAL ASSESSMENT:

**Breast/bottle:** Amount & frequency

**Bowel/bladder:** Number of wet , dry in 24 hours? Number BM's in 24 hours?

**Education:** Can add cereal; use spoon **** Iron in formula ****

If breast fed, Vitamin D and iron ****

Introduce single ingredient foods one at a time ****

**DEVELOPMENTAL SURVEILLANCE:** *(****O****bserved or* ***R****eported)*

**Social:** Smiles **** Seeks eye contact with parent ****

**Fine Motor:** Follows 180 degrees **** Grasps rattle ****

Reaches for toy **** Hands together ****

**Language:** Vocalizes **** Coos **** Laughs ****

**Gross Motor:** Rolls over belly to back **** Lifts chest up **** Prone, lifts head 90 degrees **** Head steady when sitting **** Bears some weight on legs ****

# ANTICIPATORY GUIDANCE:

**Social:** Schedules/daily routines **** Sitter ****

**Parenting:** Can’t spoil **** Different babies have different temperaments ****

**Play and communication:** Hanging toys ****

Respond to baby’s “conversation” **** Age appropriate toys ****

**** **** Head/Face

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

**** **** Ears

**** **** Nose

**** **** Mouth/Gums

**** **** Neck/Nodes

**** **** Lungs

**** **** Heart/Pulses

**** **** Chest/Breasts

**** ****

Choose toys for shape, size and texture ****

**Health:** Teething, drooling, chewing **** Clean teeth ****

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 by schedule
2. Follow up newborn hearing screen

Abdomen

**** **** Genitals

**** **** Extremities/Hips/Feet

1. Next preventive appointment at 6 months ****
2. 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