

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)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Gums
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	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: 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: (Observed or Reported)

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
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 120° 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 _____
3. Next preventive appointment at 6 months
4. Referrals for identified problems? (specify)

Signatures: _____

<https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx>