**PEDIATRIC VISIT 6 to 8 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:** (by questionnaire)

**TB (**required at **6mos.) LEAD**

Pos / Neg Pos / Neg

**PHYSICAL EXAMINATION (unclothed)**

|  |  |  |  |
| --- | --- | --- | --- |
| Wnl************ | Abn************ | *(describe abnormalities)* Appearance/Interaction GrowthSkin |  |
| **** | **** | Head/Face/Fontanelles |  |
| **** | **** | Eyes/Red reflex/Cover test |  |
| **** | **** | Ears |  |
| **** | **** | Nose |  |
| **** | **** | Mouth/Gums/Number of Teeth |  |
| **** | **** | 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:** Introduce single ingredient food weekly **** Offer cup **** Jar/table foods **** Avoid small hard foods **** Encourage self-feeding **** Only water in bedtime bottle ****

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

**Social:** Shy with strangers **** Resists pull toy **** Plays peek-a-boo ****

**Fine Motor:** Transfers toy hand to hand **** Feeds self crackers **** Works for toy out of reach ****

**Language:** Dada or Mama (non-specific) **** Turns to voice ****

Imitates speech sounds ****

**Gross Motor:** Sits alone **** Stands holding on ****

Bears weight on legs **** No head lag when pulled to sitting ****

# ANTICIPATORY GUIDANCE:

**Social:** Fear of strangers **** Separation anxiety ****

**Parenting:** Emphasize protection over discipline ****

Temper tantrums: ignore, distract ****

May need reassurance for separation anxiety ****

**Play and communication:** Water and sand play **** Toys with moving parts, holes, strings to pull **** Beginning speech sounds ****

**Health:** Fluoride if well water **** Second hand smoke ****

Clean teeth **** Use sunscreen ****

**Injury prevention:** Rear riding/rear facing infant car seat ****

Smoke detector/escape plan **** Baby proof home **** Hot water set at 120º **** Poison control # **** Choking/suffocation **** Fall prevention (heights) **** Firearms (owner risk/safe storage) **** Hot liquids **** Water safety (tub/pool) **** Don’t leave unattended ****

# PLANS/ORDERS/REFERRALS

1. Immunizations ordered (including influenza)****
2. Lead test, if positive risk assessment ****
3. Follow up newborn hearing screen ****
4. Fluoride Varnish Applied? Yes / No
5. Next preventive appointment at 9 months ****
6. Referrals for identified problems? *(specify)*

## Signatures:

[*https://mmcp.dhmh.maryland.gov/epsdt*](https://mmcp.dhmh.maryland.gov/epsdt)***Maryland Healthy Kids Program*** 2020