

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: **TB (Annual)** **LEAD**
(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

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"/>	Skin

<input type="checkbox"/>	<input type="checkbox"/>	Head/Face/Fontanelles
<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/Number of Teeth

<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs

<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts

<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals

<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone

<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: Introduce single ingredient food weekly
Offer cup Jar/table foods Avoid small hard foods
Encourage self-feeding Only water in bedtime bottle

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

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 120° 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 _____
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: _____