



## 2 weeks up to 2 Month Child Health History & Physical Check-up

PLEASE PRINT

**PERSONAL:**

Well child visit     Parent/Caregiver Request

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP
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**PRENATAL HISTORY:**     Completed previously

FIRST PRENATAL VISIT DATE	ALCOHOL, AMOUNT		TOBACCO or 2 <sup>ND</sup> HAND SMOKE EXPOSURE, AMOUNT	STREET DRUGS: AMOUNT
STDs (specify)	GROUP B STREP	HEPATITIS B	HIV	<input type="checkbox"/> POST PARTUM DEPRESSION OTHER MATERNAL PROBLEMS:
WEEKS GESTATION	<input type="checkbox"/> VAGINAL DELIVERY <input type="checkbox"/> CAESAREAN DELIVERY		BIRTH WEIGHT	WHERE DELIVERED

**PERINATAL HISTORY:**     Completed previously

PROBLEMS:	OTHER	DATE OF Discharge:
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**MEDICAL HISTORY:** (any changes or concerns since last visit)     NO     YES ( DESCRIBE)

FAMILY MEDICAL HISTORY (any changes or concerns since last visit)     NO     YES ( DESCRIBE)

ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS:     NO     YES ( DESCRIBE)

DEVELOPMENTAL ISSUES     NO     YES ( DESCRIBE)

BEHAVIORAL ISSUES     NO     YES ( DESCRIBE)

CURRENT MEDS:     VITAMINS     IRON

**DEVELOPMENTAL ASSESSMENT:**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone – lifts head, moves arms/legs equally, moro reflex)  
 YES     NO     REFERRED

**NUTRITIONAL ASSESSMENT:**

Is this a WIC participant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred				
Is your home on: <input type="checkbox"/> well water <input type="checkbox"/> city water		If on city water, is it fluoridated? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW		
<b>Breast milk</b> <input type="checkbox"/> Exclusively <input type="checkbox"/> Partially	<b># Of Wet Diapers/ Day</b>	<b># Of Soiled Diapers/ Day</b>	<b>Consistency</b> <input type="checkbox"/> LIQUID <input type="checkbox"/> SEEDY <input type="checkbox"/> SOFTLY FORMED <input type="checkbox"/> HARD FORMED	<input type="checkbox"/> <b>FORMULA:</b> _____  <b>Amount per feeding:</b>  <b>/Frequency:</b>
<b>Frequency:</b>  <b>Length of feedings:</b>	<b>Stool Color</b>	<b>Diet Adequate?</b> <input type="checkbox"/> Yes  <input type="checkbox"/> No		
<b>What other beverages does this child drink? (check all that apply):</b> <input type="checkbox"/> soy milk <input type="checkbox"/> Whole milk <input type="checkbox"/> 2% reduced fat milk <input type="checkbox"/> 1% low fat milk <input type="checkbox"/> fat free milk <input type="checkbox"/> Water <input type="checkbox"/> 100% fruit juice <input type="checkbox"/> Gatorade <input type="checkbox"/> Fruit drinks <input type="checkbox"/> soda <input type="checkbox"/> tea <input type="checkbox"/> water with sugar <input type="checkbox"/> Bottled Water				
Nutrition supplements _____ <input type="checkbox"/> other _____				

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Label



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**PHYSICAL EXAM:**

TEMP:	PULSE:	RESPIRATIONS:	LENGTH:	WEIGHT:	HEAD CIRCUMFERENCE:	CHEST CIRCUMFERENCE:
Type:			Percentile:	Percentile:	Percentile:	Percentile:

Check as appropriate $\checkmark$	N	A	N=Normal A=Abnormal	COMMENTS
1. Appearance				
2. Skin				
3. Head				
4. Eyes				
5. Ears				
6. Nose				
7. Mouth/Throat				
8. Teeth/Gums				
9. Nodes				
10. Heart				
11. Lungs				
12. Abdomen/Umbilicus				
13. Femoral Pulse				
14. External Genitalia				
15. Hip Exam				
16. Extremities				
17. Spine				
18. Neurological				
19. Other				

**LAB TESTS:**  Previously Screened

<input type="checkbox"/> NEWBORN SCREEN @ <48 hrs/age (repeat testing needed by 14 days/age)	<input type="checkbox"/> LEAD RISK ASSESSMENT	<input type="checkbox"/> OTHER (Specify, as indicated)
<input type="checkbox"/> NEWBORN SCREEN @ >48 hrs/age RESULTS REQUESTED BY:	(@ 1 mo.-6 yrs.; if positive do blood screen)	

**SENSORY SCREEN:**

VISION: (red reflex) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED	HEARING: (responds to noises, startles) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED
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**IMMUNIZATIONS PLAN:** DUE TODAY \_\_\_\_\_  ADMINISTERED  DEFERRED/PARENT DECLINED  NONE DUE

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE:**

<input type="checkbox"/> INFANT CAR SEAT	<input type="checkbox"/> "BACK TO SLEEP"	<input type="checkbox"/> CRIB/ BASSINETTE	<input type="checkbox"/> NUTRITION/FEEDING	<input type="checkbox"/> FIREARMS IN HOME
<input type="checkbox"/> DAYCARE	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> DOMESTIC VIOLENCE	<input type="checkbox"/> 2 <sup>ND</sup> HAND SMOKE
<input type="checkbox"/> SKIN CARE	<input type="checkbox"/> CIRCUMCISION CARE	<input type="checkbox"/> UMBILICAL CORD CARE	<input type="checkbox"/> READ TO BABY	<input type="checkbox"/> CHOKING, ASPIRATION
<input type="checkbox"/> PETS IN HOME	<input type="checkbox"/> FEVER EDUCATION	<input type="checkbox"/> SHAKEN BABY SYNDROME	<input type="checkbox"/> POST PARTUM DEPRESSION	<input type="checkbox"/> LEAD EXPOSURE
<input type="checkbox"/> OTHER _____		<input type="checkbox"/> LITERATURE GIVEN _____		

**ASSESSMENT/DIAGNOSIS:**

**PLAN/ORDERS/REFERRAL:**

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RETURN APPT:	ORDERS REVIEWED BY:
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Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

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