PEDIATRIC VISIT 0 to 1 MONTH

DATE OF SERVICE_______________

NAME____ M / F DATE OF BIRTH_____________ AGE________

WEIGHT_________/______% HEIGHT_________/______% HC_________/______% TEMP_____________

HISTORY:

Family health history documented? Yes / No_____________
Perinatal history documented? Yes / No________________
Concerns: _____________________________________

DEVELOPMENTAL/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

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		___________________________________
☐	☐	Skin/Umbilicus
		______________________________
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Dentition
		______________________________
☐	☐	Neck/Nodes
☐	☐	Lungs
		______________________________
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		______________________________
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		______________________________
☐	☐	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: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐
Sibling rivalry ☐
Parenting: Respond to cry ☐ Trust-building ☐
Holding, comfort ☐
Play and communication: Crying is communication ☐
Voices, mobiles, music, pictures ☐
Health: Diaper/skin care ☐ Bathing & washing hair ☐
Sneezing, hiccoughs, soft spot ☐
Taking baby's temperature ☐ Second hand smoke ☐
Injury prevention: Rear facing/rear riding infant car seat ☐
Sleep on back ☐ Smoke detector/escape plan ☐
Hot water temperature ☐ Choking/suffocation ☐
Poison control # ☐ Fall prevention (heights) ☐
Hot liquids ☐ Firearms (owner risk/safe storage) ☐
Water safety (tub) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ ____________________________
2. Second metabolic screen ☐ __________________________
3. Follow-up newborn hearing screen ☐ ___________________
4. Next preventive appointment at 2 months ☐
5. Referrals for identified problems: Yes / No *(specify)*

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Signatures: ____