

PEDIATRIC VISIT 2 to 3 MONTHS

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: _____

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

Head/Face/Fontanelles

Eyes/Red reflex/Cover test

Ears

Nose

Mouth/Gums/Dentition

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: Hold to feed Use of pacifier

If breast fed, Vitamin D Feed on demand

Growth spurts Avoid solid foods until 4-6 months

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Regards face Alert Social smile

Fine Motor: Follows 90 degrees Grasps

Language: Coos Laughs

Gross Motor: Head steady when sitting Hand brought to mouth

ANTICIPATORY GUIDANCE:

Social: Time out for parent Parental adjustment Sibling rivalry
 Father's involvement

Parenting: Comfort often Infant developing trust

Holding much of time when awake

Temperaments differ among infants

Play and communication: Infant seat Mobiles, music, pictures

Talk or sing to baby Objects to kick or bat at

Health: Fever/taking temp Rashes Diarrhea

Second hand smoke

Injury prevention: Rear riding/rear facing infant car seat

Smoke detector/escape plan Hot liquids Poison control #

Hot water temperature Water safety (tub/pool)

Choking/suffocation Firearms (owner risk/safe storage)

Fall prevention (heights) Don't leave unattended

PLANS/ORDERS/REFERRALS

1. Immunizations ordered _____

2. Second metabolic screen, if not done earlier _____

3. Follow up newborn hearing screen _____

4. Next preventive appointment at 4 months

5. Referrals for identified problems: Yes / No (specify)

Signatures: _____