

PEDIATRIC VISIT 4 to 5 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 _____
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

PHYSICAL EXAMINATION

Wnl Abn (describe abnormalities)

- Appearance/Interaction
- Growth
- _____
- Skin
- _____
- Head/Face
- Eyes/Red reflex/Cover test
- Ears
- Nose
- Mouth/Gums
- _____
- 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: Can add cereal; use spoon Iron in formula
If breast fed, Vitamin D and iron
Introduce single ingredient foods one at a time

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Smiles Seeks eye contact with parent
Fine Motor: Follows 180 degrees Grasps rattle
Reaches for toy Hands together
Language: Vocalizes Coos Laughs
Gross Motor: Rolls over belly to back Lifts chest up
Prone, lifts head 90 degrees Head steady when sitting
Bears some weight on legs

ANTICIPATORY GUIDANCE:

Social: Schedules/daily routines Sitter
Parenting: Can't spoil Different babies have different temperaments
Play and communication: Hanging toys
Respond to baby's "conversation" Age appropriate toys
Choose toys for shape, size and texture
Health: Teething, drooling, chewing Clean teeth
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 by schedule _____
 2. Follow up newborn hearing screen _____
 3. Next preventive appointment at 6 months
 4. Referrals for identified problems: Yes / No (specify)
- _____
- _____
- _____

Signatures: _____