

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 & updated? _____
Perinatal history documented & updated? _____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: _____ Child care: _____
Maternal Depression? Yes / No
Support? _____

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 Circle Positive/Negative (Annual)

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/Umbilicus

<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

<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/Circumcision

<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: 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 set at 120°
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 _____
5. Referrals for identified problems? (specify) _____

Signatures: _____