WELL CHILD BIRTH TO 1 MONTH

Today's Date:_____

Patient Name:_____ **Date of Birth**:_____
Time of Birth:_____**am/pm**

FAMILY HEALTH CENTER OF MISSION

FAMILY HISTORY: Check ☑ any that apply.
Changes in household since last visit ___Yes/No ___Not Applicable Explain_____
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent
___Other_____
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare
___Other_____
Birth weight: _____lbs _____oz
Complications at Birth: ___**NONE** __jaundice __breech __amniotic fluid inhaled __prematurity __ heart murmur
__newborn infection __newborn anemia __maternal diabetes __pregnancy induced HTN __herpes or other STDs
Other:_____

NUTRITION: We encourage breastfeeding your baby. Class offered 2nd Wednesday of the month 3:30 to 5:00 pm.
1. Does your child have any recurrent problems with feeding, bowels, weight loss? ___Yes/No
   Explain: _____
2. How often does your child feed?
   Breast-fed: Number of feedings in last 24 hours_____ Length of feedings:_____(minutes)
   Formula-fed: Type_____ Ounces:_____ Every____ hours Fortified with iron _____Yes/No.
3. Does your child receive any supplements: ____Yes/No _____fluoride _____iron _____vitamins

CHILD HEALTH: Indicate Yes/No or Check ☑ any that apply.
1. Does your child have any food or drug allergies? ___ Yes/No List_____
2. Has your child had any major illness, surgeries, injuries or hospitalizations? _____Yes/No
   List:_____
3. Does your child have any physical problems? ____Yes/No ___Low Weight Gain ___Jaundice ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other_____
4. Does your child take any medications regularly? _____Yes/No List_____

IMMUNIZATIONS: Check ☑ Yes or No
___Yes ___NO Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY: Indicate Yes/No
Vision Screen:
1. Does your child seem to focus on objects? _____Yes/No
2. Do your child's eyes appear to cross, drift or seem lazy? ___Yes/No Explain_____
3. Do your child's eyes appear unusual? ___Yes/No Explain_____

Hearing Screen:
1. Does your child respond to noises? _____Yes/No
2. Does your child respond to voices? _____Yes/No

DEVELOPMENT: Indicate Yes/No
1. Can focus on objects 8-15 inches in front of infant _____Yes/No
2. Becomes startled at loud noises _____Yes/No
3. Has equal movement of arms and legs _____Yes/No
4. Moves head from side to side while lying on stomach _____Yes/No

MENTAL HEALTH: Check ☑ any that apply.
Feelings: ___Appropriate for age ___Cries Excessively ___Cries too little ___Irritable
Social Interaction: Responds to loud noises ___Yes/No Responds to voices___ Yes/No
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ____Yes/No
Explain: _____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check here ☐ if no problems are noted.
Skin: ___rashes ___infections ___jaundice ___cyanosis (blue coloration of skin)
Eyes: ___Eye Discharge ___Deviation ___Excessive Tearing
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge
Cardio: ___History of murmur
Respiratory: ___Trouble Breathing ___Wheezing
Gastrointestinal: ___ Frequent Bowel Movements ____Vomiting
Genitourinary: ____Abnormal color of urine
Neuromuscular: ____Seizures ____uncoordinated movements
Musculoskeletal: ____Fractures ____Deformity

Form complete:___(staff initial)

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Weight:_____ Height:_____ OFC:_____ Temp:_____

(%)_____ (%)_____ (%)_____

FOR OFFICE USE ONLY

PHYSICAL EXAM:	**Normal**	**Abnormal**	**Comments**
Appearance	_____	_____	_____
Head/fontanels	_____	_____	_____
Skin/nodes	_____	_____	_____
Eyes	_____	_____	_____
Symmetric Corneal light reflex	_____	_____	_____
Conjugate gaze bilaterally	_____	_____	_____
Red Reflex present bilaterally	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth/Throat	_____	_____	_____
Neck	_____	_____	_____
Chest/breasts	_____	_____	_____
Heart/Pulses	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia/anus	_____	_____	_____
Spine/Hips	_____	_____	_____
1. Ortolani	_____	_____	_____
2. Barlow	_____	_____	_____
Extremities	_____	_____	_____
Muscle Tone	_____	_____	_____
DTRs	_____	_____	_____
Primitive Reflexes	_____	_____	_____

ASSESSMENT: **1.** Well Child **2.**_____

3. _____ **4.** _____

PLAN:

Immunizations: ___Hep B # 1 ___Hep B # 2

___Parent declines immunizations (List)_____

Lab: ___Bilirubin drawn

Medicaid Required: ___Hemoglobin Type (2 wk-old if not documented) ___PKU-Hereditary/Metabolic (2 wk-old if not documented)

Referral made to : _____

Health Education Handout Given to Parent/Guardian _____

RTC in: _____months/prn