VACCINES: P C

WELL CHILD 6 MONTHS

Today's Date:________________

Patient Name:_____________________________ Date of Birth:_____________

FAMILY HISTORY:
Changes in household since last visit ___Yes/No Explain_______________________________________
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent ___Other________________
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare ___Other_______________

NUTRITION:
1. Does your child have any recurrent problems with feeding? __No __Yes
   Child has the following problems: (circle) Persistent spitting up, vomiting, poor feeding, stomach problems
   Other:____
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. Are you giving your child any other type of nutrition? ___Yes/No List____
4. Does your child receive any supplements: _____Yes/No _____fluoride _____iron _____vitamins

CHILD HEALTH: Indicate Yes or No and 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 ___Weight Loss ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other___________________________________
4. Does your child take any medications regularly? _______Yes/No ____

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

SENSORY: Indicate Yes or No
Vision Screen:
1. Does your child seem to see well? _____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 turn his/her eyes or head to the sound of your voice? _____Yes/No
2. Does your child smile or stop crying when he/she hears a familiar voice? _____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Reaches for objects _____Yes/No
2. Responds to own name _____Yes/No
3. Vocal imitation, imitates speech sounds _____Yes/No
4. Rolls over _____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
Eyes: ___Eye Discharge ___Deviation ___Excessive Tearing
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge ___Sore throat
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 initials)

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Patient Name:______________________________ Date of Birth:________________

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	_______	_______	________________________________
Teeth	_______	_______	________________________________
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 6 Months Old 2.____

3. ________________________________ 4. ____________________________

PLAN: ____

Immunizations: ___PEDIARIX (Dtap, IPV, Hep B) ___Hib # 3 ___Prevnar ___ROTA ___Hep B # 3 ___DTaP # 3

___PENTACEL (Dtap, IPV, Hib) ___IPV # 3 ___PCV # 3 ___H1N1 Flu ___Seasonal Flu

___Parent declines vaccines (List)____

Lab Work Required for Medicaid: ___**Hct/Hgb** ___EPSDT Questionnaires: ___Lead Questionnaire given

Referral made to : ____

Health Education Handout Given to Parent/Guardian _______

RTC in : _________months/prn _________yr/prn