

NAME:
DOB:
GENDER: MALE FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues, including

Maternal Depression: Y N

Findings:

DEVELOPMENTAL SURVEILLANCE:

- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:

Breastmilk

Min per feeding: _____ Number of feedings in last 24 hrs: _____

Formula (type) _____

Oz per feeding: _____ Number of feedings in last 24 hrs: _____

Water source: _____ fluoride: Y N

Solids _____

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

Up-to-date

Deferred - Reason:

Given today: DTaP Hep B Hib IPV

PCV Hib-Hep B

DTaP-IPV-Hep B DTaP-IPV/Hib Rotavirus (RV)

LABORATORY

Newborn screening tests completed

and results obtained: Y N

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _____ (_____ %) Length: _____ (_____ %)

Head Circumference: _____ (_____ %)

Heart Rate: _____ Respiratory Rate: _____

Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

- | | | |
|------------------|--------------|-----------------|
| Appearance | Mouth/throat | Extremities |
| Head/fontanelles | Neck | Back |
| Skin | Heart/pulses | Musculoskeletal |
| Eyes | Lungs | Hips |
| Ears | Abdomen | Neurological |
| Nose | Genitalia | |

Abnormal findings:

Additional:

Subjective Hearing Screening: P F

Subjective Vision Screening: P F

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

Selected health topics addressed in any of the following areas*:

- Parental/Maternal Well-Being
- Infant Behavior
- Infant-Family Interaction
- Nutrition
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Signature/title

Name:

Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

2 Month Checkup

- Promote language using simple words
- Talk about pictures/story using simple words/sing
- Maintain consistent family routine
- Bottle-feeding every 3-4 hours
- Breastfeeding 8-12 feedings in 24 hours
- Hold to bottle-feed, no bottle propping
- No bottle in bed
- No microwave to heat milk
- Store breastmilk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Clean mouth/teeth with soft cloth twice a day
- Postpartum checkup
- Postpartum depression/family stress
- Crib safety with slats $\leq 2\text{-}3/8"$
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning
- Keep hand on infant when on bed or changing on table/couch
- No bed sharing
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Report domestic violence
- Return to work/school
- Sleep in crib on back with no loose covers
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds
- Water heater at $<120^\circ$

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No
Ages Birth to 3 months		<ul style="list-style-type: none"> Gives a startle response to loud, sudden noises within 3 feet Calms to a familiar, friendly voice Wakes up when you speak or make noise nearby Coos and gurgles Laughs and uses voice when playing Watches your face when spoken to

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:
<http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf>