

Name				Accompanied by	
Date	MRN	Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Preferred Language	

ATTACH LABEL

CAREGIVER CONCERNS/INTERVAL HISTORY: None

- PAST MEDICAL HISTORY** Reviewed and updated
SURGICAL HISTORY Reviewed and updated
FAMILY HISTORY Reviewed and updated

- MEDICATIONS** None
 Reviewed and updated
ALLERGIES No known drug allergies

- Nutrition:** Breast feeding: _____ times/day
 Pumped breast milk _____ oz/day
 Formula _____ oz/day
 Vitamin D (When breastfeeding)
 Multivitamin with iron (for premature infants)
 Water (4-8 oz/day) _____ oz/day
 Baby food _____

- Water Source:** City tap Filtered/bottled
 Well: regularly tested? Yes No

- Daily Oral Care:** Yes No No teeth

- Elimination: YES NO**
 Soft, easy to pass BMs _____
 Issues with constipation _____
 Normal urine stream _____

- Sleep:** Longest sleep stretch through the night ____ hrs
YES NO
 Safe sleep environment _____
 Night feedings _____
 Bottle in bed _____

RISK ASSESSMENT

- | | | |
|-----------------------|-----------------------|------------------------|
| HIGH | LOW | |
| <input type="radio"/> | <input type="radio"/> | Vision Concerns _____ |
| <input type="radio"/> | <input type="radio"/> | Hearing Concerns _____ |
| <input type="radio"/> | <input type="radio"/> | Lead _____ |
| <input type="radio"/> | <input type="radio"/> | TB _____ |

DEVELOPMENT: Screen or refer if concerns

- YES NO**
- Knows familiar people
 - Laughs
 - Takes turns making sounds with you
 - Makes squealing noises
 - Puts things in her mouth to explore them
 - Reaches to grab a toy he wants
 - Rolls from tummy to back
 - Leans on hands to support himself when sitting

Caregiver concerns about growth, development, behavior:

SOCIAL HISTORY: Reviewed and updated

Lives with: 1 parent 2 parents Other caregiver

Others (including siblings):

FAMILY RISK FACTORS:

Changes in family since last visit:

Caregiver job status:

Do you need additional assistance with any of the following?

- Getting enough to eat
- Relationships
- Drug abuse
- Violence/Abuse
- Financial
- Alcohol abuse
- Health Insurance
- Child care
- Other _____

Maternal/Caregiver PHQ2 Depression Screening:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- 0-Not at all 1-Several days
 2-More than half the days 3-Nearly every day

Little interest or pleasure in doing things 0 1 2 3
 Feeling down, depressed, or hopeless 0 1 2 3
 Total score _____

For scores 3 or over please complete PHQ9

PHYSICAL EXAMINATION

Length _____ cm (_____ %ile)	Weight _____ Kg (_____ %ile)	Head circumference _____ cm (_____ %ile)
VITALS:	Temp: _____	BP (if high risk) ____/____ (_____ %ile _____ %ile)
	HR: _____	Resp Rate: _____ SpO ₂ _____

Normal examination findings are listed below. Describe other findings in the area provided.

General: Well appearing, active, and alert. _____

Head: Normocephalic and atraumatic. Anterior fontanelle open and flat. _____

Eyes: Red reflex, present bilaterally. Pupils equal, round, and reactive to light. No discharge. _____

ENT: No ear deformities. Normal external canals. Tympanic membranes clear bilaterally. Nares patent. _____

Mouth: No oral lesions or thrush. _____

Neck: Supple, with full range of motion. _____

Cardiovascular: Regular rate and rhythm. Heart sounds S1, S2 normal. No murmur. _____

Chest: No increased work of breathing. Clear and symmetric breath sounds bilaterally. _____

Abdomen: Soft, non-distended, no masses, no hepatosplenomegaly. _____

Genitourinary: _____

Normal female external genitalia. _____

Normal male external genitalia. Testes descended bilaterally, no scrotal swelling, no inguinal hernia. _____

Musculoskeletal: Spine normal. Negative Ortolani and Barlow maneuvers. Moves all extremities symmetrically. _____

Neurological: Normal strength and tone. _____

Skin: Normal color. No lesions. _____

Birthmarks (if applicable) _____

Other comments:

ATTACH LABEL

ANTICIPATORY GUIDANCE:

FAMILY WELL-BEING:

- Self-care for caregivers
- Time for self & partner
- Sibling adjustment to infant
- Plan for return to work
- Resources for local child care

FAMILY NUTRITION/ORAL HEALTH:

- Feed infant based on hunger cues; soft finger foods.
- Avoid milk, fish, shellfish, egg whites, peanuts, and nuts
- Provide water in a sippy cup
- No honey until 1 year
- No bottle propping

BEHAVIOR:

- Importance of talking, reading, singing, cuddling
- Emerging infant independence
- Sleep routine: self-calming, putting self to sleep

SAFETY:

- Encourage day/night routine and supervised tummy time
- Safe sleep practices
- No swaddling after 2 months
- Water heater set below 120°
- If smoking in home: discuss quitting, limiting exposure
- Rear-facing car seat
- Baby may roll - always one hand on baby (never leave on changing table, couch, bed)
- Wash hands before feeding and after diaper changes
- Pertussis vaccine for adults in household
- Influenza and Covid-19 vaccine for household contacts

ASSESSMENT

Well Child Exam

- Normal findings (normal interval growth, age appropriate development)
- Abnormal findings _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations:

- Vaccine Information Statements given
- Vaccine counseling given
- Vaccines due:
 - HepB
 - DTaP
 - Rotavirus
 - Hib
 - PCV13
 - IPV
 - Influenza
 - COVID-19
- Catch-up vaccinations given _____
- High risk: MenACWY-CRM (Menveo) ≥2 mos
- Past adverse reactions to immunizations:
 - No
 - Yes _____

See current guidelines: <https://www.cdc.gov/vaccines/index.html>

Fluoride Varnish

- If teeth are erupted, apply fluoride in the office if not done elsewhere in the last 3 months _____

LAB: (if indicated)

Developmental Follow-up:

- No delays
- Follow-up in office
- Referral

Referral: (if indicated) Vision TB risk assessment
 Lead Hearing

1st Five Healthy Mental Development Initiative: In available counties, contact 1st Five for developmental concerns or needs assessment at <https://idph.iowa.gov/1stfive>

Early ACCESS Line: For referral of children birth to age 3 with developmental delay to local Early Access providers, call (888) 425-4371 or go to: <https://iafamilysupportnetwork.org>

Healthy Families Line: For assistance with care coordination, transportation, or health information for children birth through age 21 call (800) 369-2229

Return appointment:

- Follow-up in 3 months _____
- Follow-up hearing screen if at risk _____
- Other/referral based on risk assessment _____

Signature _____ Date _____

ATTACH LABEL

NOTES

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