

NAME _____	DOB _____	AGE _____	SEX _____	WGT _____	HGT _____	HEAD CIRC _____	SCREEN DATE _____
ALLERGIES _____				CURRENT MEDS _____			

**HISTORY**

Concerns and questions \_\_\_\_\_

Follow up on previous concerns \_\_\_\_\_

- See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_

**SOCIAL/FAMILY HISTORY**

- See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_  
Family Situation     No change \_\_\_\_\_  
Parents working outside home     Mother     Father  
Child care     Yes     No     Type \_\_\_\_\_  
Changes since last visit     Yes     No \_\_\_\_\_

**CURRENT HEALTH INDICATORS**

- See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_

- Nutrition     Breast     Bottle  
Formula \_\_\_\_\_  
Ounces/day \_\_\_\_\_  
Hours between feeding \_\_\_\_\_  
Solid Foods \_\_\_\_\_  
Feeding/24 hours \_\_\_\_\_  
Vitamins/Fluoride \_\_\_\_\_  
Source of Water \_\_\_\_\_

- Elimination     NL \_\_\_\_\_  
Sleep     NL \_\_\_\_\_  
Behavior     NL \_\_\_\_\_

- Toxic Exposure  
Passive Smoking     Yes     No  
Lead Risk     High Risk     Low Risk  
 Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead.  
 Has a sibling or playmate who has or did have lead poisoning?

- Development  
 Growth     Plotted on growth chart  
Gross Motor:  
 Sits with support  
 Rolls over  
 Stands when placed and bears weight

**CURRENT HEALTH INDICATORS (CONTINUED)**

- Fine Motor:  
 Transfers objects from hand to hand  
 Grasps and mouths objects; starts to self-feed  
 Rakes in small objects  
Sensory:  
 Appears to see  
 Turns to sounds  
Communication:  
 Vocalizes single consonants ("dada," "baba")  
 Babbles, laughs and squeals  
 Plays by making sounds  
 Shows interest in toys  
Social:  
 Social smile  
 Shows pleasure  
 Shows differential recognition of parents  
 May begin to show signs of stranger anxiety  
Other:  
 Self-comforts

**PHYSICAL EXAMINATION**

- = NL  
 General Appearance     Skin  
 Head     Fontanelle  
 Eyes     Red Reflex     Strabismus     Appears to see  
 Ears     External     Internal     Appears to hear  
 Mouth     Throat     Nose  
 Lungs  
 Heart  
 Abdomen  
 Genitalia     Male - testes down     Female  
 Extremities     Hips     Back  
 Femoral pulses    Right \_\_\_\_\_    Left \_\_\_\_\_  
 Neurological

Abnormal findings/comments:

**ANTICIPATORY GUIDANCE/HEALTH EDUCATION**

- Discussed     Handouts given  
Nutrition:     Milk  
 Breast feeding  
 Formula (supplement or if not breast fed)  
 Begin cup  
 Solid foods  
 No honey  
 Elimination

**ANTICIPATORY GUIDANCE/HEALTH EDUCATION (CONT)**

- Sleep:     Back to sleep  
 Blankets/pillows  
 Own crib  
Development/Behavior:  
 Social  
 Communication  
 Physical  
Injury Prevention:  
 Auto/car seat  
 Poisons  
 Falls  
 Hanging cords  
 Electrical outlets  
 Choking  
 No shaking  
 Burns  
 Smoke detector  
 Water heater  
 Fire retardant clothes  
 Sun  
 Water  
 Guns

**PLAN**

- Immunizations (see Vaccine Administration Record)     UTD  
Labs  
 Hgb/Hct     Blood Lead Level if one or more risks identified  
 Other \_\_\_\_\_

**REFERRALS**

- Development  
 One delay - rescreen at next visit  
 Two or more delays - **Referred to:**  
  
 Further Medical Treatment/Diagnosis - **Referred to:**

**FOLLOW UP /NEXT VISIT:**

\_\_\_\_\_  
Please Print Facility or Clinician Name

\_\_\_\_\_  
Signature of Clinician

