WELL CHILD VISIT

2 Month

Name _____Age in Months _____ Date of Visit _____

Concerns/Discussion

- ☐ Feeding
- ☐ Stool/Voiding
- ☐ Illness/Accidents
- ☐ Sleeping position
- ☐ Fussy baby/Colic
- ☐ Child care
- ☐ Parent returning to work/school
- ☐ Parent's health/mood
- ☐ Other concerns
- ☐ Parent/Infant interaction (observe)

Nutrition

Breast

- ☐ Length _____ min.
- ☐ Frequency q _____ hrs

Formula

- ☐ Type _____
- ☐ Amount _____ oz.
- ☐ Frequency q _____ hrs.
- ☐ Vitamins (if indicated)

Guidance

- ☐ No solid foods
- ☐ Breast feeding (discourage supplementation)
- ☐ Bottle Feeding
  Fe fortified formula only
  No sleeping with bottle

Developmental/Behavioral

- ☐ Coos/Vocalizes
- ☐ Smiles responsively
- ☐ Reacts to Visual/Auditory cues
- ☐ Lifts head/neck (prone position)
- ☐ Temperament/Parent Description
  _____
  _____

Physical Exam

- ☐ General
- ☐ Wt _____ % _____
  Ht _____ % _____
  HC _____ % _____
  Monitor growth chart
- ☐ Temp _____
- ☐ Skin (Jaundice)
- ☐ Nodes
- ☐ Head (Fontanelle/Sutures)
- ☐ Eyes (Red Reflex)
- ☐ Ears
- ☐ Nose
- ☐ Oropharynx
- ☐ Neck (Torticollis)
- ☐ Chest/Breast
- ☐ Lungs
- ☐ Cardiovascular
- ☐ Abdomen
- ☐ Genitalia
- ☐ Hips (Clicks)
- ☐ Neuro
- ☐ Evidence of Neglect/Abuse

Screening/Immunizations

Screening

- ☐ Metabolic/Hemoglobinopathy (results & f/u)
- ☐ Hearing Screen (results & f/u)
- ☐ Vision (exam only)

Immunizations

- ☐ Per ACIP schedule (Record below)

Anticipatory Guidance

- ☐ Car seat
- ☐ Sleep position (back only)
- ☐ Cigarette smoke
- ☐ Avoidance of falls
- ☐ Avoiding sleep problems
- ☐ Interaction/Stimulation for baby
- ☐ Day care selection
- ☐ Appropriate toys
- ☐ Temperature taking
- ☐ Illness instruction

Immunizations given:

_____

_____

_____

Record all abnormal findings below.

_____

_____

_____

Assessment and Plan: _____

_____

PHN Referral (if indicated) _____ WIC Referral (if indicated) _____

Physician Signature: _____

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

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