WELL CHILD VISIT

4 Month

Name ________________________________ Age in Months ____________ Date of Visit _________________________

Concerns/Discussion

☐ Feeding
☐ Stool/Voiding
☐ Sleep
☐ Parent/Sibling adjustment
☐ Illness/Accidents
☐ Other concerns
☐ Parent/Infant Interaction (observe)

Nutrition

Breast

☐ Frequency q ______ hrs

Formula

☐ Type ______________________
☐ Amount ______ oz.
☐ Frequency q ______ hrs.
☐ Vitamins (if indicated)

Guidance

☐ Introduction of solids
(spoon only)
☐ Breast feeding
(discuss supplementation)
☐ Bottle Feeding
Fe fortified formula only
No sleeping with bottle

Developmental/Behavioral

☐ Vocalizes/Babbles
☐ Recognizes parents' voice
☐ Grasping objects
☐ Rolls over
☐ Head/Neck control
☐ Lifts chest (prone position)
☐ Temperament/Parent Description
____
____

Physical Exam

☐ General
☐ Wt ______ % ______
Ht ______ % ______
HC ______ % ______
Monitor growth chart
☐ Temp _______
☐ Skin
☐ Nodes
☐ Head
☐ Eyes (Strabismus)
☐ Ears
☐ Nose
☐ Oropharynx
☐ Neck (Torticollis)
☐ Chest/Breast
☐ Lungs
☐ Cardiovascular (murmurs)
☐ Abdomen
☐ Genitalia
☐ Hips (Clicks)
☐ Neuro (tone/strength)
☐ Evidence of Neglect/Abuse

Screening/Immunizations

Screening

☐ F/U metabolic and hearing from birth
☐ Vision (exam only)

Immunizations

☐ Per ACIP schedule (Record below)

Anticipatory Guidance

☐ Car seat
☐ Sleep position
☐ Avoidance of fall
☐ Pet safety
☐ Bathing safety
☐ Shaken baby/Abuse
☐ Choking discussion
☐ Lead poisoning hazards
☐ Plastic bags/Balloon hazards
☐ Baby "Walker" safety
☐ Illness instructions

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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