



WELL CHILD VISIT

1-4 Week

Name _____ Age in Weeks _____ Date of Visit _____

Concerns/Discussion

- Feeding
- Stool/Voiding
- Sleep position
- Support systems
- Sibling adjustment
- Child care anticipation
- 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

- W.I.C. (if appropriate)
- No solid foods
- Breast feeding
(discourage supplementation)
- Bottle Feeding
Fe fortified formula only
No sleeping with bottle

Developmental/Behavioral

- Responds to sound
- Early eye fixation
- Startle reflex
- Moves all extremities
- Temperament/Parent Description

Physical Exam

- General (Irritability/Lethargy)
- 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 (distention)
- Musculoskeletal
- Hips (Clicks)
- Neuro (Moro reflex)
- 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
- Crib safety
- Sleep/SIDS (back only)
- Avoidance of falls
- Avoid cigarette smoke
- Smoke alarms
- Appropriate babysitters
- Water heater temp (<125 degrees)
- "Shaken baby" counseling
- When to contact health professional

Immunizations given:

Record all abnormal findings below.

Assessment and Plan: _____

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

Physician Signature: _____