

NEWBORN - 3 MONTH VISIT

Patient Name: _____

Sponsor SSN last four: _____

Patient Date of Birth: _____

Please provide a good contact phone number: HOME _____ CELL _____

Do you have any specific concerns today? _____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
		Allergies Asthma Other:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements): <input type="checkbox"/> Infant Multivitamin 1 ml per day

Please list any known **allergies** your child has (drug, food, latex) _____ No Allergies

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness less than 5 years old
 Birth Defects Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? Yes No

Is your child's sponsor currently deployed? Yes No Is this visit **deployment** related? Yes No

Source of Medical Information: Mother Father Other: _____

Immunizations: Did you child receive the Hepatitis B vaccine at birth? Yes No Unsure

Does your child attend daycare? Yes No

Does anyone in the family smoke or is your child exposed to secondhand smoke? Yes No

Are the instructions for Patient Understood by Caregiver/Patient? Yes No

Do you & your child feel safe at home? Yes No

What is your preferred method for learning: Verbal Written Other: _____

Preferred language: English Other: _____

Are there cultural or religious considerations that affect your child's healthcare? No Yes _____

Are either of your child's parents on PRP status? Yes No

----- Additional Hx/Prevention -----

weeks pregnant at delivery? _____ (Estimated gestational age)

Type of Delivery (check all that apply): Vaginal Forceps Vacuum-assisted C-section Breech

Complications at birth? Yes No _____

Prenatal complications? Yes No List: _____

Group B Strep positive? Negative Positive (with adequate treatment) Positive (without adequate treatment)

Born as a Single Birth? Yes No

Baby's hearing screen normal? Yes No Not performed

Metabolic Screen? Normal Pending Abnormal: _____

Breastfeeding? Yes No Per every 24 hours: Hours between? _____ Minutes per breast? _____

Bottle feeding? Yes No Per every 24 hours: Ounces per feed? _____ Hours between? _____ Brand? _____

Number of wet diapers per day? _____ Circle if you have concerns about: Bowel movements Constipation Sleep problems

Does either parent have: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? Yes No

----- Milestones -----

Check all the following that apply to your child:

2 WEEK	2 MONTH	
<input type="checkbox"/> Eats well	<input type="checkbox"/> Starts to smile	<input type="checkbox"/> Head steady in upright position
<input type="checkbox"/> Follows face	<input type="checkbox"/> Coos	<input type="checkbox"/> Diminished newborn reflexes
<input type="checkbox"/> Turns to voice	<input type="checkbox"/> Different cry for different needs	<input type="checkbox"/> Symmetric movement
<input type="checkbox"/> Calms to voice	<input type="checkbox"/> Looks at parents	<input type="checkbox"/> Can indicate boredom
<input type="checkbox"/> Sucks, swallows and breathes without difficulty	<input type="checkbox"/> Lifts head and chest off surface	<input type="checkbox"/> Calms self

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Weight		HR		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/>
Length		RR		
OFC		SpO2		
				Technician Signature: _____

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/Nontender/FROM/Fontanelle open & flat/no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no lesions	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, no lumbosacral pits	<input type="checkbox"/>
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/>
<input type="checkbox"/>	Hips:	<input type="checkbox"/> Full ROM, Neg Barlow/Ortolani	<input type="checkbox"/>
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down	
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: Passed hearing screen at birth Metabolic screen: Normal Abnormal

ASSESSMENT: Well baby: normal growth & development for age
 ASQ performed. NI development in all areas.

PLAN: 400 IU Vitamin D supplement/day
 Immunizations per clinic schedule

F/U: at next well child visit at ___ months, sooner if parental concerns

Patient and/or parent verbalizes understanding of treatment and plan Anticipatory guidance handout provided

PREVENTION: Back to Sleep Safety/Falls Breast/bottle feeding Tummy Time Car Seat
 For fever, seek care Tobacco avoidance

RECORDS MAINTAINED AT:		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

STANDARD FORM 600 Overprint

Signature: _____ Date _____