

2-6 Months

Department of State Health Services Child Health Record Preventive Health Visit

Client Information

Name: _____
DOB: _____ / _____ / _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother _____ Father _____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____ P _____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: _____ Y _____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health/Interim History

Allergies:
Does the system review note any problems
or parent concerns: _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Physical Examination

Temp _____ Pulse _____ Resp _____
FOC _____ Length _____ Weight _____
(%) _____ (%) _____ (%) _____

N A NE	N A NE
_____ Appearance	_____ Heart/pulses
_____ Head/fontanel	_____ Lungs
_____ Skin/nodes	_____ Abdomen
_____ Eyes (RR)	_____ Genitalia/anus
_____ Ears	_____ Spine/hips
_____ Nose	_____ Extremities
_____ Mouth/throat	Neurologic:
_____ Teeth	_____ Muscle tone
_____ Neck	_____ DTRs
_____ Chest/breasts	_____ Primitive reflexes

Additional documentation:

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____ Y _____ N
**If answered yes, further assessment needed.*
Breast-fed: Number of feedings in last 24 hours: _____
Length of feedings: _____ **WIC:** _____ Y _____ N
Formula-fed: Type: _____
Iron fortified: _____ Y _____ N
Ounces consumed in 24 hours: _____ Fluoride: _____ Y _____ N
Solid foods introduced at age:

Sensory

Vision Screen: _____ Normal _____ Abnormal
Hearing Screen: _____ Normal _____ Abnormal
Screen used: _____ Hearing Checklist for Parents

Health Education

Injury Prevention

_____ Car safety restraints
_____ Falls, Infant walker
_____ Burns
_____ Choking management
_____ Sleep position (SIDS)
_____ Passive smoking
_____ Pool/bath safety

Health Promotion

_____ Immunizations
_____ Thermometer use, Tylenol
_____ Teething, wipe teeth
_____ When to call doctor
_____ Well-child care
_____ Family planning

Behavior

_____ Parent/infant interaction
_____ Sleeping
_____ Inappropriate expectations
_____ Daycare/babysitters

Nutrition

_____ Breastfeeding
_____ No solids until 4 months
_____ Formula preparation
_____ Infant held (no bottle in bed)

Assessment

Plan

Dental referral: _____
WIC: _____ Referred _____ Refused _____ N/A
Immunizations: Up to date _____ To be given today _____ Deferred
Explain:
Lab: Hct/Hgb _____ Lead questionnaire (at 6 months): _____
Newborn Screening: Up to date _____ To be done today
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title: _____

