

**Pediatric Health Maintenance Flow Sheet  
Newborn – 4 years of age**

Patient's Name \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

<b>Guidelines</b>	<b>NB</b>	<b>1 mo</b>	<b>2 mo</b>	<b>4 mo</b>	<b>6 mo</b>	<b>9 mo</b>	<b>12 mo</b>	<b>15 mo</b>	<b>18 mo</b>	<b>24 mo</b>	<b>3 yr</b>	<b>4 Yr</b>
<b>Date</b>												
History (initial and interim)												
Immunization Review												
Head Circumference												
Height and Weight												
Blood Pressure												
Hearing Screen												
Vision Screen												
Developmental Assess.												
Dental Inspection												
Physical Examination												
Anticipatory Guidance												
Hematocrit/Hemoglobin							*	*	*	*	*	*
Injury Prevention												
Interpretive Conference												
Nutritional Assessment												
Sleep Position Counsel												
Violence Prevention												
Lead Risk Assessment											●	●
Blood Lead Testing					*					*	●	●
Sickle Cell Testing (EPSDT)												
Cholesterol Testing										*	*	*
Tuberculin (TB) Test						*	*	*	*	*	*	*

\*High Risk Patients ●If not performed earlier