

DATE \_\_\_\_\_

PATIENT NAME	DOB	SEX	PARENT NAME
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Allergies	Current Medications
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Prenatal/Family History

Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

<b>Birth History</b> Birth Wt.: _____ Gestation: _____ <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section Complications <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Anticipatory Guidance/Health Education</b> (√ if discussed)
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**Interval History:**  
 (Include injury/illness, visits to other health care providers, changes in family or home)

Apnea  Y  N  Monitor

**Nutrition**

Breast every \_\_\_\_\_ hours  
 Formula \_\_\_\_\_ oz every \_\_\_\_\_ hours  
 With iron  Y  N  
 Type or brand \_\_\_\_\_

City water    Well water  
 Solids  Y  N

**Elimination**

Normal    Abnormal

**Sleep**

Normal (4 hours)    Abnormal  
 Abnormal Findings and Comments  
 If yes, see additional note area on next page

**WIC**  Y  N   **ISS**  Y  N

**Screening:**

**Hearing**  
 Responds to Sounds  
 Neonatal ABR or OAE results in chart

**Vision**  
 Looks at faces  
 Parental observation/concerns

**Neonatal Metabolic Screen in Chart**  
 Y  N   Test Date: \_\_\_\_\_  
 Normal    Pending    Today

**Immunizations:**

Immunizations Reviewed, Given & Charted –  
*if not given, document rationale*

DTaP    IPV    HepB    Hib    PCV  
 MCIR checked/updated  
 Acetaminophen \_\_\_\_\_ mg. q. 4 hours

**Next Well Check: 6 months of age**

**Developmental Questions and Observations on Page 2**

Provider Signature: \_\_\_\_\_

Patient Unclothed  Y  N

Review of Systems	Physical Exam		Systems
	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Abnormal Findings and Comments  
 If yes, see additional note area on next page

Results of visit discussed with parent  Y  N

**Plan**

History/Problem List/Meds Updated  
 Referrals  
 WIC    ISS    Early On  
 Children Special Health Care Needs  
 Transportation  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_

**Healthy and Safe Habits**

**Injury and Illness Prevention**

Appropriate car seat placed in back seat  
 Keep home and car smoke-free  
 Safety Locks on Cabinets/smoke detectors  
 Don't leave baby alone in tub or high places; always keep hand on baby  
 Water temp. <120 degrees/test with wrist  
 Wash hands often/clean toys  
 Childproof home - (hot liquids, cigarettes, alcohol, poisons, medicines, outlets, cords, small/sharp objects, plastic bags, safety locks)  
 Put baby to sleep on back/Safe Sleep  
 Crib Safety  
 Never shake baby  
 Avoid direct sun  
 Know signs of illness/emergency procedures  
 Don't use baby walkers

**Nutrition**

Breastfeed or give iron-fortified formula  
 If breastfeeding only, give iron supplement  
 Introduce solid foods at 4-6 months  
 Wait one week or more to add new food

**Oral Health**

Don't put baby to bed with bottle  
 Discuss teething  
 Discuss good family oral health habits

**Parent-Infant Interaction**

Laugh with baby  
 Learn baby's temperament  
 Console, hold, cuddle, rock, play with baby  
 Talk, sing, play music, and read to baby  
 Daily and Bedtime Routine

**Family Support and Relationships**

Encourage partner to help care for infant  
 Take time for self and spend time alone with your partner  
 Keep in contact with friends, family  
 Family Planning  
 Choose responsible babysitters  
 Discuss child care, returning to work  
 Substance Abuse, Domestic Violence, Depression

**Community Interaction**

Consider parenting classes  
 Maintain ties to community

## WELL CHILD EXAM-INFANCY: 4 Months

DATE	PATIENT NAME	DOB
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### Developmental Questions and Observations

Ask the parent to respond to the following statements about the infant:

- |  |                          |   |
|--|--------------------------|---|
| <b>Yes</b>                               | <b>No</b>                |   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | Please tell me any concerns about the way your baby is behaving or developing |
| <hr style="border: 0.5px solid black;"/> |                          |   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby cries when upset and seeks comfort.                                   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby smiles and laughs.  |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby is sleeping well.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby is eating and growing well.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby can see and hear.   |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby likes to look at and be with me.                                      |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby reaches for objects and can hold them.                                |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby rolls or tries to roll over from tummy to back.                       |
| <input type="checkbox"/>                 | <input type="checkbox"/> | My baby lets me know what it wants and needs.                                 |

Ask the parent to respond to the following statements:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | I am sad more often than I am happy.                          |
| <input type="checkbox"/> | <input type="checkbox"/> | I have more good days with my baby than bad days.             |
| <input type="checkbox"/> | <input type="checkbox"/> | I have people who help me when I get frustrated with my baby. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am enjoying my baby more days than not.                     |

Provider to follow up as necessary

### Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Infant Development			Parent Development		
Holds head upright in prone position	Yes	No	Looks at infant and shares baby's smiles	Yes	No
Laughs responsively	Yes	No	The parent comforts baby effectively	Yes	No
Follows past midline	Yes	No	Parent and baby are interested in and respond to each other	Yes	No
No persistent fist clenching	Yes	No	Parent seems depressed, angry, tired, overwhelmed, or uncomfortable	Yes	No
Raises body on hands	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. ( <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> )		
Seeks eye contact with parent	Yes	No			

### Additional Notes from pages 1 and 2:

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Staff Signature: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

## **Your Baby's Health at 4 Months**

### Milestones

*Ways your baby is developing between 4 and 6 months of age.*

Says “dada” or “baba”.

May be unsure of strangers.

Smiles, laughs, and squeals responsively.

Rolls over from front to back.

Shows interest in toys.

Tries to pass toys from one hand to the other.

May get upset when separated from familiar person(s).

Sits with support.

Enjoys a daily routine.

### For Help or More Information:

#### **Breast feeding, food and health information:**

- Women, Infant, and Children (WIC) Program, call 1-800-26-BIRTH.
- The National Women's Health Information Center Breastfeeding Helpline! Call with questions at 1-800-994-WOMAN (9662). Or visit the website at: <http://www.4woman.gov/breastfeeding>

#### **Car seat safety:**

Contact the Auto Safety Hotline at 1-888-327-4236.

#### **For information about childhood development:**

Contact EarlyOn Michigan at 1-800-327-5966 or the Michigan Head Start Associations at 1-517-374-6472.

#### **For information about childhood immunizations:**

Call the National Immunization Program Hotlines at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish).

#### **For help finding childcare:**

Child Care Licensing Agency, Michigan Department of Consumer & Industry Services, 1-517-373-8300.

#### **Domestic Violence hotline:**

National Domestic Violence Hotline - (800) 799-SAFE (7233)

### Safety Tips

Always keep one hand on your baby when he/she is on a bed, sofa, or changing table so he/she does not roll off.

### Safety Tips

Never leave your baby alone in your home, car or community.

Use a rear-facing car seat for your baby on every ride. Buckle him/her up in the back seat, away from the air bag.

Keep the Poison Help Line by your phone: 1-800-222-1222

### Health Tips

Check-ups are a good time to ask the doctor or nurse questions about your baby. Make a list of questions before you go.

Remember to bring your baby's immunization card with you to every visit. Babies can get immunizations ('shots') even when they have a slight cold.

Your baby is still getting all the nutrition he/she needs from breast milk or formula. Try to keep breast-feeding until your baby is at least 12 months old. Wait to give your baby cereal or other solid foods until he/she is at least 5 or 6 months old.

Check how your baby sees and hears. Watch to see if his/her eyes follow moving objects. Watch to see if he/she turns toward a loud or sudden sound.

Keep putting your baby to sleep on his/her back. Keep soft bedding and stuffed toys out of the crib. Make sure your baby sleeps by him/herself in a crib or portable crib.

Call your baby's doctor or nurse before your next visit if you have any questions or concerns about your baby's health, growth, or development.

### Parenting Tips

Sing, talk, read to and play with your baby every day. Look at your baby and repeat the sounds he/she makes.

Put your baby on their tummy to play on the floor. Put toys close to him/her so he/she can reach for them.

Try to make a daily routine for you and your baby.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.