

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
	%		%		%				

Birth History Birth Wt.: _____ Gestation: _____ <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section Complications <input type="checkbox"/> Y <input type="checkbox"/> N	Anticipatory Guidance/Health Education (√ 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 (6 - 8 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 voice & noise (parent report)
 Responds to noisemaker (optional)
 Parental observation/concerns
Vision
 Fixes and follows
 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: 9 months of age

Developmental Questions and Observations on Page 2

Provider Signature: _____

Patient Unclothed Y N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<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
- Pool/water safety
- Safety Locks on Cabinets
- Don't leave baby alone in tub or high places; always keep hand on baby
- Wash your hands often/clean toys
- Childproof home - (hot liquids, alcohol, poisons, medicines, outlets, cords, small-sharp objects, plastic bags, safety locks)
- Never shake baby
- Limit time in sun/use sunscreen on baby
- Check home for lead poisoning hazards
- Don't use baby walkers

Nutrition

- Breastfeed or give iron-fortified formula
- Cup for water/juice – limit juice
- Supervise eating/ Avoid choke foods
- Wait one week or more to add new food

Oral Health

- Don't put baby to bed with bottle
- Discuss teething
- Fluoride/clean baby's teeth daily

Parent-Infant Interaction

- Use distraction as discipline
- May get upset when separated from familiar person
- Talk, sing, play music, and read to baby
- Daily and Bedtime Routine (put baby to bed awake)
- Safe Exploration Opportunities
- Pat a Cake, Peek a Boo, So Big

Family Support and Relationships

- Take time for self and spend time alone with your partner
- Sibling involvement
- Family Planning
- Chose responsible babysitters
- Discuss child care, returning to work
- Substance Abuse, Domestic Violence, Depression

Community Interaction

- Consider parenting classes/support groups
- Maintain or expand ties to community

WELL CHILD EXAM-INFANCY: 6 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:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Please tell me any concerns about the way your baby is behaving or developing: |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby seeks comfort when upset. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby smiles and laughs. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby says things like “da da” or “ba ba”. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby eats some solid foods. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby sits with help/support. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby can pick up objects. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby likes to look at and be with me. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby rolls over. |

Ask the parent to respond to the following statements:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | I am sad more often than I am happy. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have people who help me when I get frustrated. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am enjoying my baby more days than not. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a daily routine that seems to work. |
| <input type="checkbox"/> | <input type="checkbox"/> | I keep in contact with family and friends. |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel safe with my partner. |

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		
Turns to sounds/voices	Yes	No	Parent looks at infant and shares baby’s smiles	Yes	No
Can be comforted most of the time	Yes	No	Parent comforts baby effectively	Yes	No
Smiles, squeals and laughs responsively	Yes	No	Parent and baby are interested in and respond to each other	Yes	No
Has no head lag when pulled to sit	Yes	No	Parent seems depressed, angry, tired, overwhelmed, or uncomfortable	Yes	No
			Parent notices and responds to baby’s wants and needs	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. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

Your Baby's Health at 6 Months

Milestones

Ways your baby is developing between 6 and 9 months of age.

Babbles, imitates vocalizations.

Responds to own name.

Holds small things between his/her fingers.

Feeds himself/herself with fingers.

Starts to drink from cup.

Enjoys a daily routine.

Sits up well and may pull to stand.

Crawls, creeps, moves forward by scooting on bottom.

May be unsure of strangers.

May start to comfort self – sucking thumb or holding special toy.

May get upset when separated from familiar person.

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.

Toy and Baby Product Safety:

Consumer Product Safety Commission, 1-800-638-2772.

Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or www.safekids.org

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).

Domestic Violence hotline:

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

Health Tips

Signs that your baby is ready to start solid food:

- He/she can sit up with little or no support.
- He/she shows you they want to try your food.
- He/she can use their tongue to push food into their throat.

Your baby will let you know when he/she has had enough to eat. Stop feeding your baby when he/she spits food out, closes his/her mouth, or turns his/her head away.

Let your baby begin to learn to drink from a cup. Put water, breast milk, or formula in it. Don't let your baby take a bottle to bed.

Continue to put 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.

Parenting Tips

Show your baby picture books and talk about the pictures. Sing simple songs and say nursery rhymes over and over.

Give your baby plenty of time to play on his/her tummy on the floor. Put toys just out of reach so he/she will try to crawl. Start playing simple games together like "Peek-a-Boo" and "Pat-a-Cake."

Make regular times for eating, sleeping and playing with 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.

Safety Tips

Make your home safe before for your baby starts to crawl. You will need to keep doing this for several years.

- Put away small objects and things that break.
- Tape electric cords to the wall; put covers on outlets.
- Put safety gates at the top and bottom of stairs.
- Store poisons and pills in a locked cabinet.
- Poison Help Line: 1-800-222-1222

Baby walkers cause more injury than any other baby product. Instead of a walker, use a seat without wheels or put your baby on his tummy on the floor.