

Name _____ FMP/SSN last four: _____ DOB: _____

Email Address : _____ Contact Phone Number: _____

4 - 11 MONTH VISIT

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)
Hayfever/allergies	Example circumcision		Allergies	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements): <input type="checkbox"/> Infant Multivitamin 1 ml per day
Asthma			Asthma	
Premie			Diabetes	
Overweight			Heart Disease	
Chronic ear infections			Obesity	
Other: (reflux)				

Circle if anyone in the family has had:

Genetic or Metabolic Disease / Birth Defects / Kidney Disease / Deafness < 5 years old/

Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Please list any known **allergies** your child has (drug, food, latex) _____

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

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

Are your child's immunizations up to date? Yes No Unsure

Who does your child live with? _____

Does your child attend daycare? Yes No

Does anyone in the family smoke? Yes No

Do you feel safe at home? Yes No

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

Preferred language: English Other: _____

Please See Reverse Side

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

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

Ethnic Origin Filipino Hispanic Asian/Pacific Islander Southeast Asian Other Unknown Decline to Respond

Race Asian/Pacific Islander African American Caucasian Western Indian Other Unknown Decline to Respond

Birth History: (if not completed before)

weeks pregnant at delivery? _____

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

Complications at birth? _____

Prenatal complications? Yes No List: _____

Group B Strep positive? Yes No Don't Know

Baby's hearing screen normal? Yes No Not performed

Breastfeeding? Yes No How often? _____ Minutes per breast? _____ Concerns? _____

Bottle feeding? Yes No Brand? _____ Ounces per feed? _____ Ounces per day? _____

Cereal? Yes No How many times per day? _____ Solid foods? Yes No How many times per day? _____

Number of wet diapers per day? _____ Stools per day? _____

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems

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

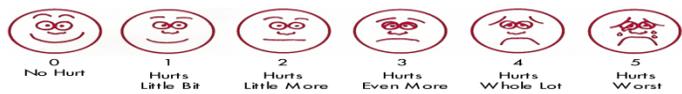
In the past week, has your child had:

Fever	Yes/No	Duration? _____	Wheezing	Yes/No	Duration? _____
Congestion	Yes/No	Duration? _____	Vomiting	Yes/No	Duration? _____
Runny nose	Yes/No	Duration? _____	Diarrhea	Yes/No	Duration? _____
Pulling at ears	Yes/No	Duration? _____	Appetite Less	Yes/No	Duration? _____
Eye discharge	Yes/No	Duration? _____	Rash	Yes/No	Duration? _____
Cough	Yes/No	Duration? _____	Other (describe) _____		

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child:

4 MONTH	6 MONTH	9 MONTH
<input type="checkbox"/> Turns toward voices	<input type="checkbox"/> Babbles	<input type="checkbox"/> Sits without help
<input type="checkbox"/> Head steady when sitting	<input type="checkbox"/> Responds to name	<input type="checkbox"/> Crawls
<input type="checkbox"/> Bears weight on legs	<input type="checkbox"/> Passes toys from hand to hand	<input type="checkbox"/> Pulls to a stand
<input type="checkbox"/> Pushes chest off surface when on tummy	<input type="checkbox"/> Sits without help if propped	<input type="checkbox"/> Feeds self with fingers
<input type="checkbox"/> Brings hands together	<input type="checkbox"/> Rolls from back to front	<input type="checkbox"/> Grabs small objects with hands
<input type="checkbox"/> Reaches for objects	<input type="checkbox"/> Rolls from front to back	<input type="checkbox"/> Plays Peek-a-Boo
<input type="checkbox"/> Laughs		<input type="checkbox"/> Shy with strangers
		<input type="checkbox"/> Remembers an object is there if covered

PLEASE GIVE THIS FORM TO YOUR PROVIDER'S ASSISTANT

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"/> No
Length		RR		
OFC				

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, no umbilical/inguinal hernia	<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, Symmetric skin folds <input type="checkbox"/> Neg Barlow/Ortolani (at 4 months)	<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
 Fluoride supplementation (begins at 6 months)
 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: Nutrition/Solid foods Dental care Safety/Falls Car Seat Child-proofing the house Tobacco avoidance

Signature: _____
Date: _____
Stamp:

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