

Name \_\_\_\_\_ FMP/SSN last four: \_\_\_\_\_ DOB: \_\_\_\_\_

Email Address : \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

# NEWBORN - 3 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	<b>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</b> <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

Did you child receive the Hepatitis B vaccine at birth?  Yes  No  Unsure

Who does your baby live with? \_\_\_\_\_

Does your child attend daycare?  Yes  No

Does anyone in the family smoke?  Yes  No

Do you & your child feel safe at home?  Yes  No

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

Preferred language:  English  Other: \_\_\_\_\_

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

**Please See Reverse Side**

<b>RECORDS MAINTAINED AT:</b> 		
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

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 at previous visit)**

# 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

Birthweight? \_\_\_\_\_

Breastfeeding?  Yes  No How often? \_\_\_\_\_ Minutes per breast? \_\_\_\_\_ Concerns? \_\_\_\_\_

Bottle feeding?  Yes  No Brand? \_\_\_\_\_ Ounces per feed? \_\_\_\_\_ Ounces 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) _____		

**Check all the following that apply to your child:**

2 WEEK	2 MONTH	
<input type="checkbox"/> Responds to voices	<input type="checkbox"/> Coos/makes noises	<input type="checkbox"/> Will look from side to side
<input type="checkbox"/> Fixes on your face	<input type="checkbox"/> Responds to your voice	<input type="checkbox"/> Has hands open more than 50% of the time
<input type="checkbox"/> Moves arms and legs equally	<input type="checkbox"/> Lift head and chest up when on tummy	<input type="checkbox"/> Smiles
<input type="checkbox"/> Lift head up when on tummy	<input type="checkbox"/> Head steady when sitting up	

**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 Technician Signature: _____
Length		RR		
OFC		SpO2		

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	<b>General:</b>	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	<b>Head/Neck:</b>	<input type="checkbox"/> NCAT/Nontender/FROM/Fontanelle open & flat/no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	<b>Eyes:</b>	<input type="checkbox"/> RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	<b>R ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>L ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>Nose:</b>	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist, no lesions	<input type="checkbox"/>
<input type="checkbox"/>	<b>Lungs:</b>	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	<b>CV:</b>	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	<b>Abd:</b>	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	<b>Ext/Spine:</b>	<input type="checkbox"/> NL, FROM, nontender, no edema, no lumbosacral pits	<input type="checkbox"/>
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/>
<input type="checkbox"/>	<b>Hips:</b>	<input type="checkbox"/> Full ROM, Neg Barlow/Ortolani	<input type="checkbox"/>
<input type="checkbox"/>	<b>Neuro:</b>	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	<b>Genitalia:</b>	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down	
<input type="checkbox"/>	<b>Other findings:</b>	<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  
 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:**  Back to Sleep    Safety/Falls    Breast/bottle feeding    Tummy Time    Car Seat  
 For fever, seek care    Tobacco avoidance

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

Date:

Stamp:

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