Today's Date:_____

Patient Name:	FMP and Sponsor SSN last four:	Contact Number: Date of Birth:

2 MONTH WELL CHECK

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 (Include Dates)	Family History (biological siblings, parents, grandparents)	Medications (PLEASE INCLUDE DOSAGE)
		Allergies **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):**

Please list any known allergies your child has (drug, food, latex)_____ **☐ No Allergies**

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness before age 5

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

Did your child receive the Hepatitis B vaccine at birth? ☐ Yes ☐ No

Who does the child live with? _____

Does your child attend daycare? ☐ Yes ☐ No

Does anyone in the family smoke or is your child exposed to secondhand smoke? ☐ Yes ☐ No

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

BIRTH HISTORY: (If not completed at previous visit):

 # Weeks pregnant at delivery?_____

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

Complications at birth? _____

Prenatal Complications? ☐ Yes ☐ No List if yes:_____

Group B Strep Positive? ☐ Yes ☐ No ☐ Don't know

Passed Hearing screen? ☐ Yes ☐ No ☐ Not Performed

Birth weight? _____

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

Formula feeding? ☐ Yes ☐ No **Brand**_____**Ounces per feed**_____**Ounces per day** _____

Number of wet diapers per day_____**Number of stools per day**_____

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

Check all the following that apply to your child:

Social/ Cognitive Communicative/ Physical Development	
☐ Starting to smile	☐ Watches things as they move
☐ Coos or makes gurgling sounds	☐ Moves all arms and legs equally

Preferred Language: ☐ English ☐ Other:_____

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

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

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

Today's Date:_____

RR		**LT**	
HR		**Naked WT**	
Temp			
		HC	

Pain: □ **Yes** □ **No** **Location of Pain** _____

Immunizations UTD per AFCITA: □ Yes □No **Technician Signature:**_____

*Other VS per Provider request

HPI:

N E	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT/Nontender/FROM	□
□	**Eyes:**	□ RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Symmetric leg folds	□
□	**Neuro:**	□ Normal tone/strength/symmetry	□
□	**Genitalia:**	□ Nl female/no adhesions □ Nl male, Testes down	
□	**Other findings:**	□	□

LABS/X-RAYS: □ H&H (12 months): □ Lead Screening (if applicable)

PLAN:

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 □ Sippy Cups/No Bottle □ Dental care □ Safety/Falls □ Car Seat □ Child-proofing the house □ Tobacco avoidance

Signature:_____**Date:**_____
Stamp:

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

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