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

STANDARD FORM 600 Overprint

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Child's Name: _____ Date: _____

Deployment, and Safety Screening Questionnaire

Deployment:

1. Is a parent currently deployed? YES NO
2. Is a parent under orders for deployment within the next three months? YES NO
3. Has a parent returned from a deployment with the last year? YES NO

Safety:

1. Are you in a relationship now or have you ever been is a relationship in which you have been harmed or felt afraid of your partner? YES NO
2. Has your partner ever hurt any of your children? YES NO
3. Are you afraid of your current partner? YES NO
4. Do you have any pets in the house? YES NO
5. Has your partner or child ever threatened or hurt any of the pets? YES NO
6. Are there any guns in your house? YES NO

Date: _____ Today your child saw: _____

SCAN TO PRINT YOUR FORMS AT HOME!

NAVAL MEDICAL CENTER PORTSMOUTH PEDIATRTICS

Weight:_____kg (_____%) _____lbs _____oz
Height: _____cm (_____%) _____in Head Circ: _____cm (_____%)

Follow up with your PCM in_____weeks / months or sooner if you have any further concerns.

☐ **Prescriptions provided today:**

_____

_____

- New Prescriptions TEXT Q-Anyhwhere: 833-217-2199
- Medication Refills call 757-953-6337(MEDS)

☐ **Labs ordered today:**

_____ **(Please complete by _____)**

(NMCP Laboratory-1L; Hours are 0700-1630; Walk-in Appts Only)

☐ **Radiology – X-rays/MRI/CT/Ultrasound ordered today:**

_____ **(Please complete by _____)**

(1st Floor South; X-rays by walk in appt 0700-1530; Call 953-XRAY to schedule for Ultrasound/CT/MRI))

☐ **Referrals ordered today:**

_____

- Referrals to the MTF call 1-866-645-4584 in 48-72 hours to schedule your appointment
- Network referral status call Humana Military 1-800-444-5445 **OR** view referral status via MHS Genesis Patient Portal

☐ **Immunizations due today:**

_____

(Call 1-866-645-4584 to schedule an Immunization appointment at one of the TPC Branch Clinics)

☐ **Additional Instructions:**

_____

Important Phone Numbers:

- NMCP Pediatric Clinic (757)-953-7716
- Appointment Line: (866)-645-4584
- 24 hour Counseling Self-Referral Hotline: (800)-342-9647
- Infant and Toddler Connection of VA: (800)-234-1448
- Nurse Advice Line: (800)-TRICARE (option#1)
- Poison Control: (800)-222-1222
- Humana Military: (800)-444-5445
- NMCP Pediatrics Fax: 757-953-0868
- Fleet and Family: 757-444-6289(NAVY)
- Tricare: 1-877-2273 (TRICARE)

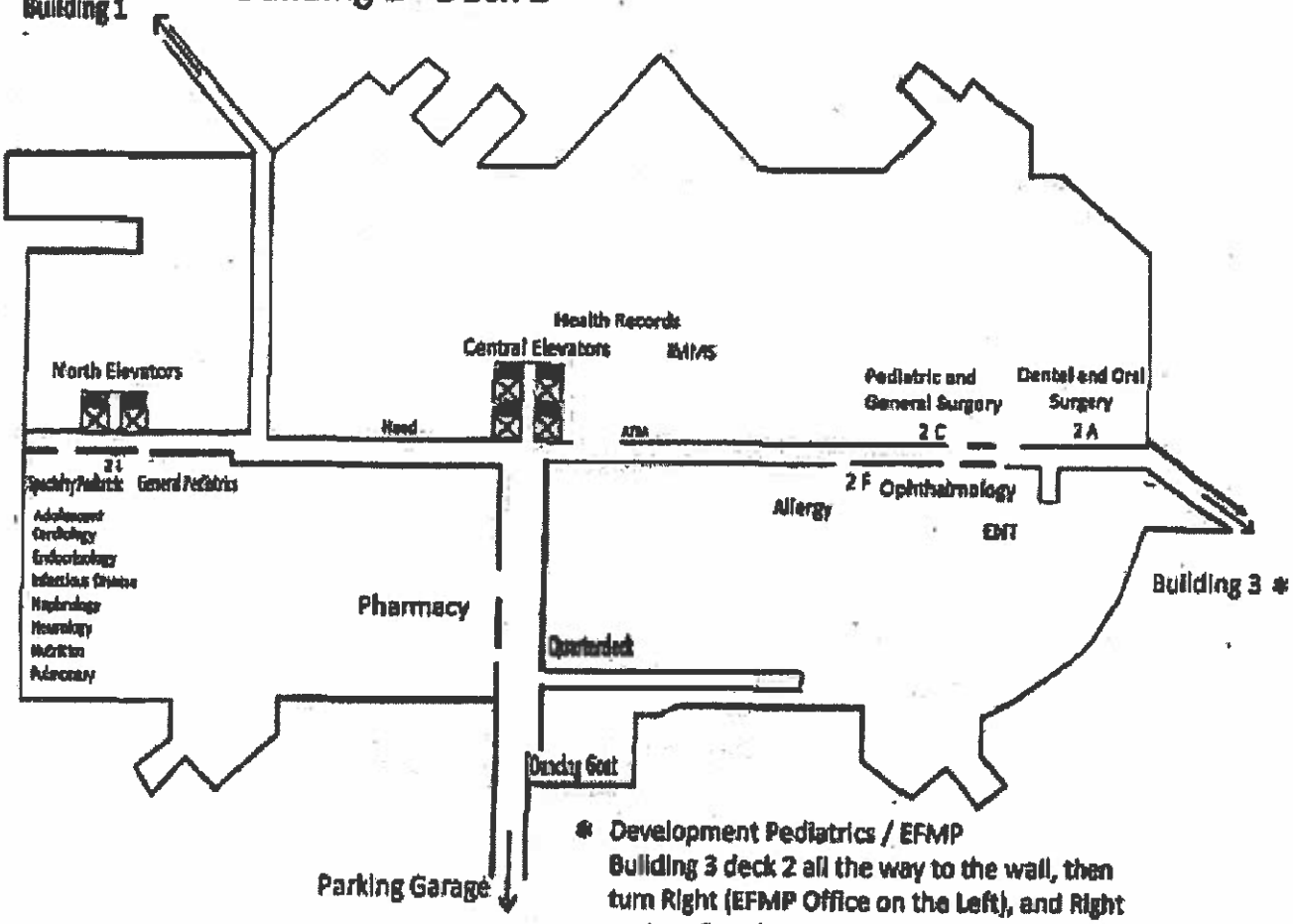
INTERACTIVE CUSTOMER EVALUATION

Additional Resources:

- **MHS Genesis Patient Portal:** https://myaccess.dmdc.osd.mil/identitymanagement/app/login
- Military Onesource
  - https://www.militaryonesource.mil/
  - Counseling Services – 12 sessions without referral; 24 hour hotline (800)-342-9647
  - Optometry-NO referral required
- **Humana Military:** https://www.humana.com
- **Fleet and Family:** https://www.navymwrmidlant.com/
- **Health Information:** https://healthychildren.org/English/Pages/default.aspx

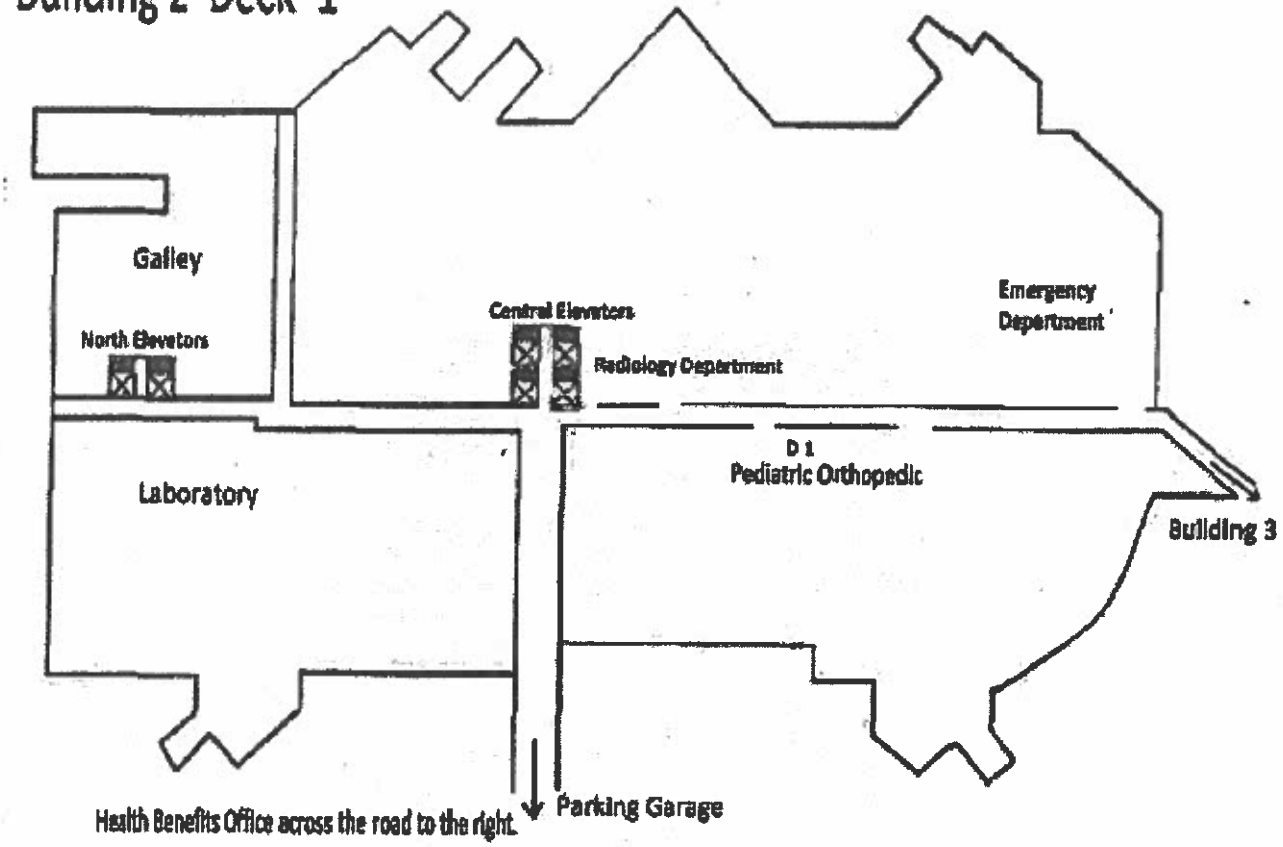
Date: _____ Today your child saw: _____

Building 2 Deck 2



* Development Pediatrics / EFMP
Building 3 deck 2 all the way to the wall, then turn Right (EFMP Office on the Left), and Right again at Development Pediatric Office.

Building 2 Deck 1



BRIGHT FUTURES HANDOUT ▶ **PARENT**

2 MONTH VISIT

Here are some suggestions from Bright Futures experts that may be of value to your family.

Bright Futures

HOW YOUR FAMILY IS DOING

- If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance.
- Find ways to spend time with your partner. Keep in touch with family and friends.
- Find safe, loving child care for your baby. You can ask us for help.
- Know that it is normal to feel sad about leaving your baby with a caregiver or putting him into child care.

FEEDING YOUR BABY

- Feed your baby only breast milk or iron-fortified formula until she is about 6 months old.
- Avoid feeding your baby solid foods, juice, and water until she is about 6 months old.
- Feed your baby when you see signs of hunger. Look for her to
  - Put her hand to her mouth.
  - Suck, root, and fuss.
- Stop feeding when you see signs your baby is full. You can tell when she
  - Turns away
  - Closes her mouth
  - Relaxes her arms and hands
- Burp your baby during natural feeding breaks.

If Breastfeeding

- Feed your baby on demand. Expect to breastfeed 8 to 12 times in 24 hours.
- Give your baby vitamin D drops (400 IU a day).
- Continue to take your prenatal vitamin with iron.
- Eat a healthy diet.
- Plan for pumping and storing breast milk. Let us know if you need help.
  - If you pump, be sure to store your milk properly so it stays safe for your baby. If you have questions, ask us.

If Formula Feeding

- Feed your baby on demand. Expect her to eat about 6 to 8 times each day, or 26 to 28 oz of formula per day.
- Make sure to prepare, heat, and store the formula safely. If you need help, ask us.
- Hold your baby so you can look at each other when you feed her.
- Always hold the bottle. Never prop it.

HOW YOU ARE FEELING

- Take care of yourself so you have the energy to care for your baby.
- Talk with me or call for help if you feel sad or very tired for more than a few days.
- Find small but safe ways for your other children to help with the baby, such as bringing you things you need or holding the baby's hand.
- Spend special time with each child reading, talking, and doing things together.

YOUR GROWING BABY

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Hold, talk to, cuddle, read to, sing to, and play often with your baby. This helps you connect with and relate to your baby.
- Learn what your baby does and does not like.
- Develop a schedule for naps and bedtime. Put him to bed awake but drowsy so he learns to fall asleep on his own.
- Don't have a TV on in the background or use a TV or other digital media to calm your baby.
- Put your baby on his tummy for short periods of playtime. Don't leave him alone during tummy time or allow him to sleep on his tummy.
- Notice what helps calm your baby, such as a pacifier, his fingers, or his thumb. Stroking, talking, rocking, or going for walks may also work.
- *Never hit or shake your baby.*

Helpful Resources:

Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

2 MONTH VISIT—PARENT

SAFETY

- Use a rear-facing–only car safety seat in the back seat of all vehicles.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- Your baby's safety depends on you. Always wear your lap and shoulder seat belt. Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
- Always put your baby to sleep on her back in her own crib, not your bed.
  - Your baby should sleep in your room until she is at least 6 months old.
  - Make sure your baby's crib or sleep surface meets the most recent safety guidelines.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Swaddling should not be used after 2 months of age.
- Prevent scalds or burns. Don't drink hot liquids while holding your baby.
- Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F /49°C.
- Keep a hand on your baby when dressing or changing her on a changing table, couch, or bed.
- Never leave your baby alone in bathwater, even in a bath seat or ring.

WHAT TO EXPECT AT YOUR BABY'S 4 MONTH VISIT

We will talk about

- Caring for your baby, your family, and yourself
- Creating routines and spending time with your baby
- Keeping teeth healthy
- Feeding your baby
- Keeping your baby safe at home and in the car

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to https://brightfutures.aap.org.

The information contained in this handout should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original handout included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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