Today's Date:_____

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

2 WEEK-1 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 you 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	
☐ Fixes on face	☐ Eats well
☐ Lifts chin of surface	☐ Can suck, swallow and breathe easy

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

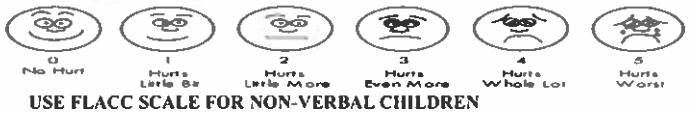
Is the child's sponsor currently deployed? ☐ Yes ☐ No

Is this visit deployment related? ☐ Yes ☐ No

Today's Date:_____

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

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



USE FLACC SCALE FOR NON-VERBAL CHILDREN

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

*Other VS per Provider request

HPI:

NE	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

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)

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:

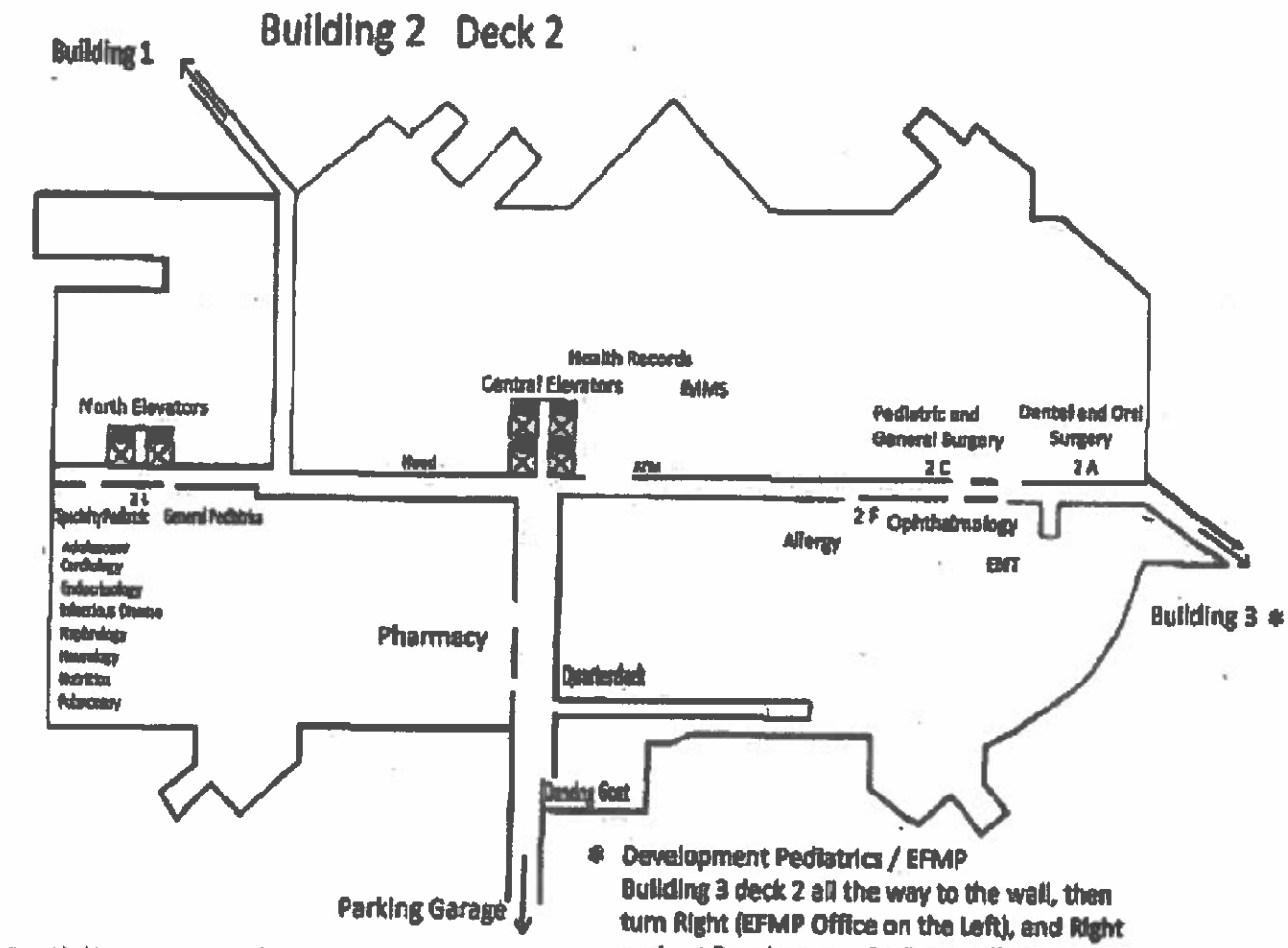
- NMCP Pediatric Clinic (757)-953-7716
- Appointment Line: (866)-645-4584
- 24 hour Counseling Self-Referral Hotline: (800)-342-9647
- Infant and Toddler Connection of VA: (800)-234-1448
- Nurse Advice Line: (800)-TRICARE (option#1)
- Poison Control: (800)-222-1222
- Humana Military: (800)-444-5445
-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

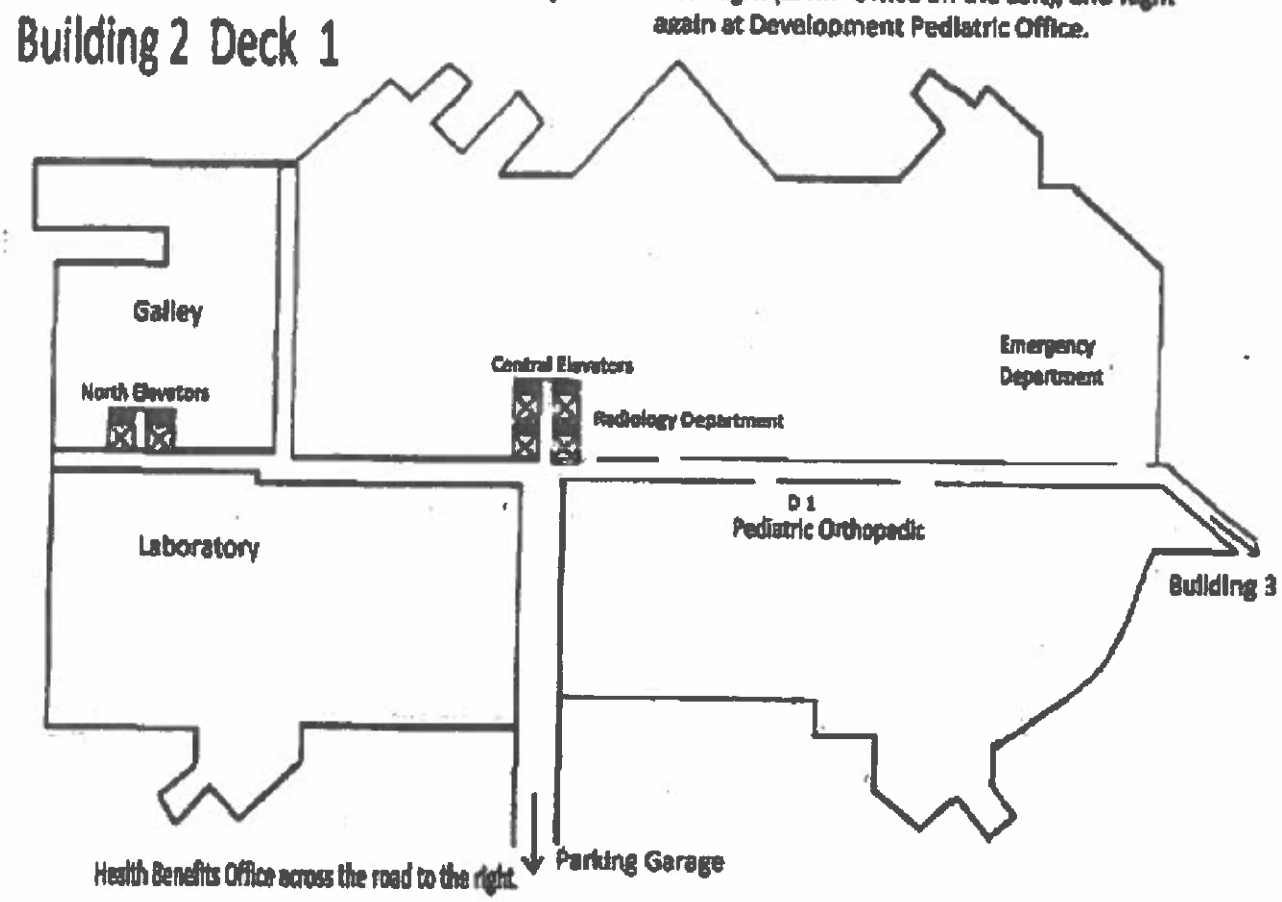
INTERACTIVE CUSTOMER EVALUATION

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: _____





BRIGHT FUTURES HANDOUT ▶ **PARENT**

1 MONTH VISIT

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

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.
- Ask us for help if you have been hurt by your partner or another important person in your life. Hotlines and community agencies can also provide confidential help.
- Tobacco-free spaces keep children healthy. Don't smoke or use e-cigarettes. Keep your home and car smoke-free.
- Don't use alcohol or drugs.
- Check your home for mold and radon. Avoid using pesticides.

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 she is hungry. Look for her to
  - Put her hand to her mouth.
  - Suck or root.
  - Fuss.
- Stop feeding when you see your baby is full. You can tell when she
  - Turns away
  - Closes her mouth
  - Relaxes her arms and hands
- Know that your baby is getting enough to eat if she has more than 5 wet diapers and at least 3 soft stools each day and is gaining weight appropriately.
- Burp your baby during natural feeding breaks.
- Hold your baby so you can look at each other when you feed her.
- Always hold the bottle. Never prop it.

If Breastfeeding

- Feed your baby on demand generally every 1 to 3 hours during the day and every 3 hours at night.
- Give your baby vitamin D drops (400 IU a day).
- Continue to take your prenatal vitamin with iron.
- Eat a healthy diet.

If Formula Feeding

- Always prepare, heat, and store formula safely. If you need help, ask us.
- Feed your baby 24 to 27 oz of formula a day. If your baby is still hungry, you can feed her more.

HOW YOU ARE FEELING

- Take care of yourself so you have the energy to care for your baby. Remember to go for your post-birth checkup.
- If you feel sad or very tired for more than a few days, let us know or call someone you trust for help.
- Find time for yourself and your partner.

CARING FOR YOUR BABY

- Hold and cuddle your baby often.
- Enjoy playtime with your baby. Put him on his tummy for a few minutes at a time when he is awake.
- Never leave him alone on his tummy or use tummy time for sleep.
- When your baby is crying, comfort him by talking to, patting, stroking, and rocking him. Consider offering him a pacifier.
- *Never hit or shake your baby.*
- Take his temperature rectally, not by ear or skin. A fever is a rectal temperature of 100.4°F/38.0°C or higher. Call our office if you have any questions or concerns.
- Wash your hands often.

Helpful Resources: National Domestic Violence Hotline: 800-799-7233 | Smoking Quit Line: 800-784-8669
Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

1 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.
- Make sure your baby always stays in her car safety seat during travel. If she becomes fussy or needs to feed, stop the vehicle and take her out of her seat.
- 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 in 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.
  - Don't put soft objects and loose bedding such as blankets, pillows, bumper pads, and toys in the crib.
- Swaddling should be used only with babies younger than 2 months.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Keep hanging cords or strings away from your baby. Don't let your baby wear necklaces or bracelets.
- Always keep a hand on your baby when changing diapers or clothing on a changing table, couch, or bed.
- Learn infant CPR. Know emergency numbers. Prepare for disasters or other unexpected events by having an emergency plan.

WHAT TO EXPECT AT YOUR BABY'S 2 MONTH VISIT

We will talk about

- Taking care of your baby, your family, and yourself
- Getting back to work or school and finding child care
- Getting to know your baby
- 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.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®