**Today's Date:**_____

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

# 4 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 (Dates) | Family History (biological siblings, parents, grandparents) | Medications (PLEASE INCLUDE DOSAGE) |
|---|---|---|---|
| | | **Allergies**<br>**Asthma**<br>**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 | |
|---|---|
| □ Smiles on their own or in response to someone | □ Reaches for objects they want |
| □ Holds head steady when held upright | □ Rolls from front onto back |
| □ Coos and babbles | □ Uses arms to push chest off surface when on tummy |
| □ Elicits attention and likes to play | □ Brings things to mouth |

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** | | **HT** | |
| | | **Naked WT** | |
| | | | |
| | | **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:**

| 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**