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 **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	
☐ 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

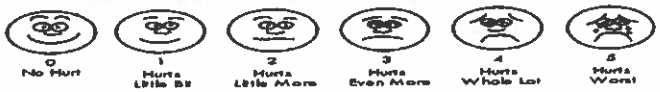
Is the child's sponsor currently deployed? ☐ Yes ☐ No

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

23 Jan 2012 SF 600

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**

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

Date: _____ Today your child saw: _____

NAVAL MEDICAL CENTER PORTSMOUTH PEDIATRTICS

SCAN TO PRINT YOUR FORMS AT HOME!

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)

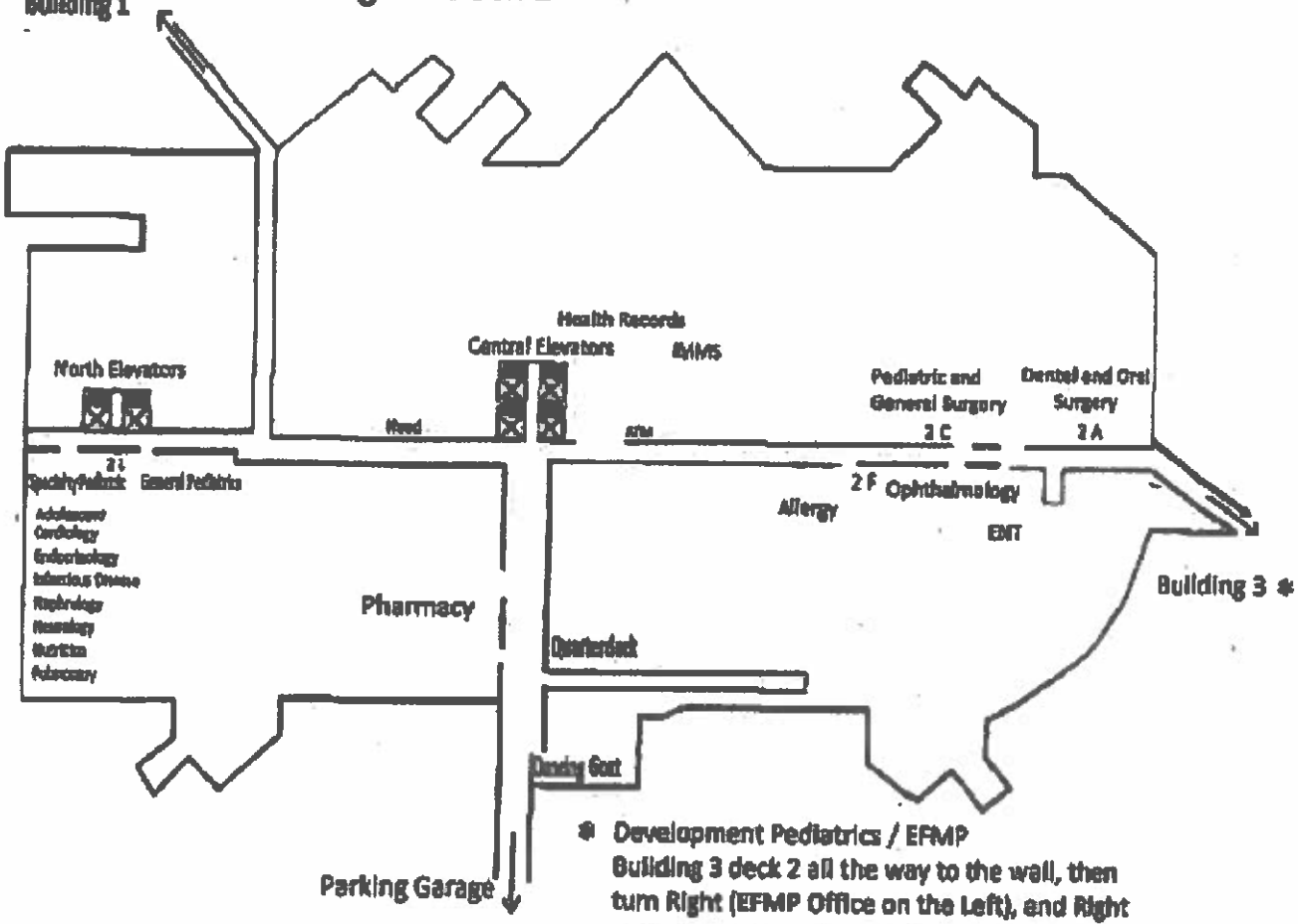
INTERACTIVE CUSTOMER EVALUATION

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

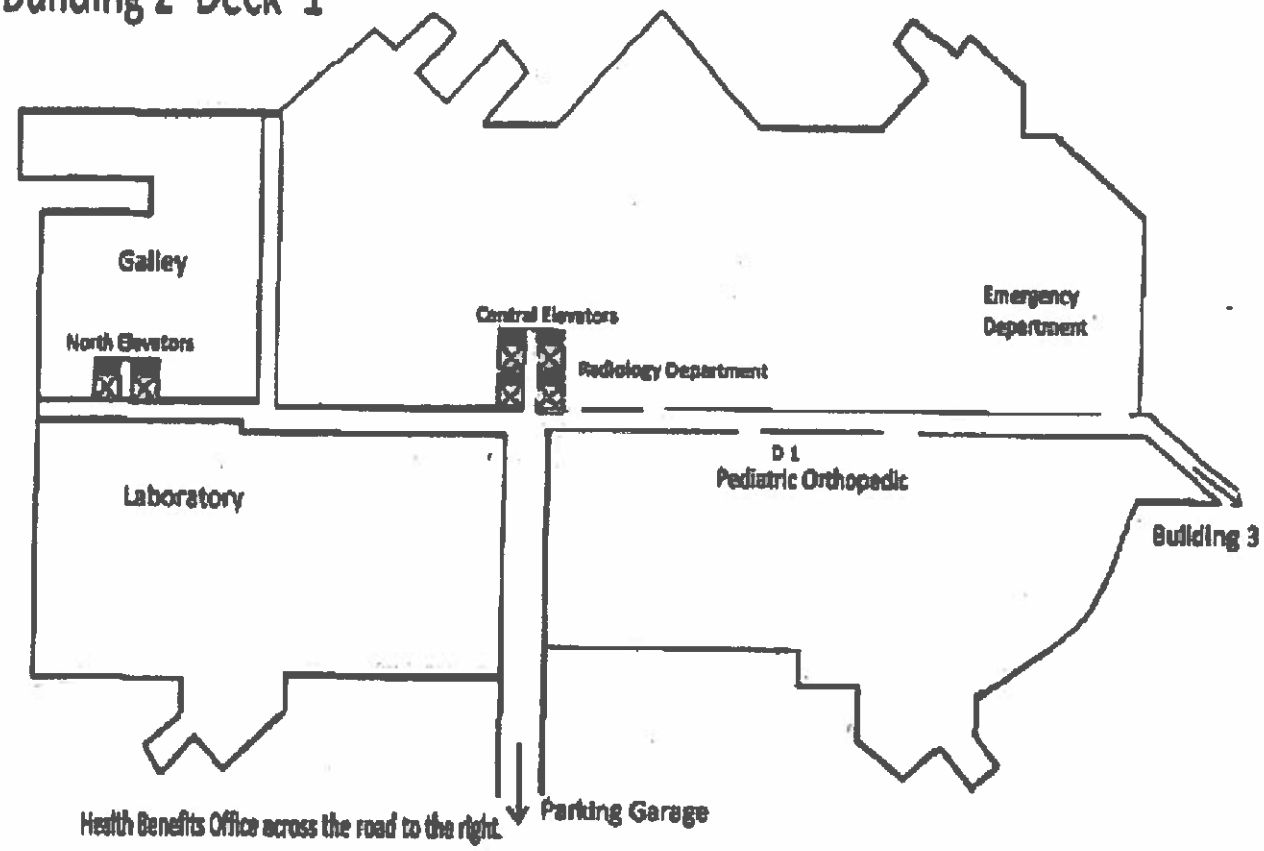
Date: _____ Today your child saw: _____

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**

4 MONTH VISIT

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

HOW YOUR FAMILY IS DOING

- Learn if your home or drinking water has lead and take steps to get rid of it. Lead is toxic for everyone.
- Take time for yourself and with your partner. Spend time with family and friends.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.

FEEDING YOUR BABY

- For babies at 4 months of age, breast milk or iron-fortified formula remains the best food. Solid foods are discouraged until about 6 months of age.
- Avoid feeding your baby too much by following the baby's signs of fullness, such as
  - Leaning back
  - Turning away

If Breastfeeding

- Providing only breast milk for your baby for about the first 6 months after birth provides ideal nutrition. It supports the best possible growth and development.
- Be proud of yourself if you are still breastfeeding. Continue as long as you and your baby want.
- Know that babies this age go through growth spurts. They may want to breastfeed more often and that is normal.
- If you pump, be sure to store your milk properly so it stays safe for your baby. We can give you more information.
- Give your baby vitamin D drops (400 IU a day).
- Tell us if you are taking any medications, supplements, or herbal preparations.

If Formula Feeding

- Make sure to prepare, heat, and store the formula safely.
- Feed on demand. Expect him to eat about 30 to 32 oz daily.
- Hold your baby so you can look at each other when you feed him.
- Always hold the bottle. Never prop it.
- Don't give your baby a bottle while he is in a crib.

YOUR CHANGING BABY

- Create routines for feeding, nap time, and bedtime.
- Calm your baby with soothing and gentle touches when she is fussy.
- Make time for quiet play.
  - Hold your baby and talk with her.
  - Read to your baby often.
- Encourage active play.
  - Offer floor gyms and colorful toys to hold.
  - Put your baby on her tummy for playtime. Don't leave her alone during tummy time or allow her to sleep on her tummy.
- Don't have a TV on in the background or use a TV or other digital media to calm your baby.

HEALTHY TEETH

- Go to your own dentist twice yearly. It is important to keep your teeth healthy so you don't pass bacteria that cause cavities on to your baby.
- Don't share spoons with your baby or use your mouth to clean the baby's pacifier.
- Use a cold teething ring if your baby's gums are sore from teething.
- Don't put your baby in a crib with a bottle.
- Clean your baby's gums and teeth (as soon as you see the first tooth) 2 times per day with a soft cloth or soft toothbrush and a small smear of fluoride toothpaste (no more than a grain of rice).

Helpful Resources:

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

4 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 in your bed.
  - Your baby should sleep in your room until she is at least 6 months of age.
  - 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.
- Drop-side cribs should not be used.
- Lower the crib mattress.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F /49°C.
- Prevent scalds or burns. Don't drink hot drinks when holding your baby.
- Keep a hand on your baby on any surface from which she might fall and get hurt, such as a changing table, couch, or bed.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- Keep small objects, small toys, and latex balloons away from your baby.
- Don't use a baby walker.

WHAT TO EXPECT AT YOUR BABY'S 6 MONTH VISIT

We will talk about

- Caring for your baby, your family, and yourself
- Teaching and playing with your baby
- Brushing your baby's teeth
- Introducing solid food
- Keeping your baby safe at home, outside, 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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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®