Name FMP/SSN last four: DOB:

Email Address : Contact Phone Number:

NEWBORN - 3 MONTH VISIT

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) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **Premie** **Overweight** **Chronic ear infections** **Other: (reflux)**	Example circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** ❑ Infant Multivitamin 1 ml per day

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify _____

Circle if anyone in the family has had:

Genetic or Metabolic Disease / Birth Defects / Kidney Disease / Deafness < 5 years old /
Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Please list any known **allergies** your child has (drug, food, latex) _____

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

Did you child receive the Hepatitis B vaccine at birth? ❑ Yes ❑ No ❑ Unsure

Who does your baby live with? _____

Does your child attend daycare? ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

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

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Please See Reverse Side

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

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Birth History: (if not completed at previous visit)

weeks pregnant at delivery? _____

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

Complications at birth? _____

Prenatal complications? ❑ Yes ❑ No List:_____

Group B Strep positive? ❑ Yes ❑ No ❑ Don't Know

Baby's hearing screen normal? ❑ Yes ❑ No ❑ Not performed

Birthweight? _____

Breastfeeding? ❑ Yes ❑ No How often? _____ Minutes per breast?_____ Concerns?_____

Bottle feeding? ❑ Yes ❑ No Brand? _____ Ounces per feed? _____ Ounces per day? _____

Number of wet diapers per day? _____ Stools per day? _____

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

Does either parent have: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? ❑ Yes ❑ No

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Cough	Yes/No	Duration?_____	Other (describe)_____		

Check all the following that apply to your child:

2 WEEK	2 MONTH	
❑ Responds to voices	❑ Coos/makes noises	❑ Will look from side to side
❑ Fixes on your face	❑ Responds to your voice	❑ Has hands open more than 50% of the time
❑ Moves arms and legs equally	❑ Lift head and chest up when on tummy	❑ Smiles
❑ Lift head up when on tummy	❑ Head steady when sitting up	

PLEASE GIVE THIS FORM TO YOUR PROVIDER'S ASSISTANT