SOUTHLAKE PEDIATRICS
HEALTH SUPERVISION VISIT 2 WEEKS

Name: ______________________________ DOB: __________

Date of Visit ____________________________ Age __________

Parental Language Barrier: ☐ N ☐ Y ____________________

PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

☐ No Concerns

____

____

____

PAST MEDICAL HISTORY

Birth Hospital ______________________________

Baby's last name in hospital ______________________

Delivery: ☐ Vaginal ☐ C-section

Perinatal problems ___________________________

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Birth Wt. ________ D/C Wt. ________ Apgars _______/_______

Length ________ Head Circum __________ Bilirubin __________

Hep B shot given? No ☐ Yes ☐ Date ______________

Hearing Screen: ☐ Normal ☐ Abnormal

Medication: _________________________________

Discharge diagnoses: __________________________

PRESENT HISTORY

Feeding: ☐ Breast ☐ Formula ____________________

Spitting/Gas ________________________________

BM's, Urine stream ___________________________

Sleep ______________________________________

DEVELOPMENT

Temperament/Colic ___________________________

Sees, Follows _______________________________

Head Control ________________________________

Other ______________________________________

SOCIAL/FAMILY

Parents/Caregiver Smoker ☐ Yes ☐ No ______________

Sibling/Household members & ages __________________

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____

Family medical history ________________________

____

Parents'/Caregivers education/work ________________

____

Environmental (Support Systems, Sibling Rivalry, Financial Support, Family Planning, Gun in Home, etc.)

____

____

Information completed by: ______________________

Relationship to child: ______________________

PHYSICAL EXAMINATION

Length _________ % ________ Weight _________ % _________

HC ______ % ______ Temp _____ Pulse _____ RR _____ Pain ______

N	AB		COMMENTS
☐	☐	Gen. Appearance	____________
☐	☐	Skin	____________
☐	☐	Head/Fontanel	____________
☐	☐	Eyes/RR	____________
☐	☐	Ears/Nose/Oropharynx	____________
☐	☐	Neck/Nodes	____________
☐	☐	Chest/Lungs	____________
☐	☐	Cardiovascular/Pulses	____________
☐	☐	Abdomen/Cord	____________
☐	☐	Genitalia	____________
☐	☐	Musculoskeletal/Hips	____________
☐	☐	Neuro/Reflexes /Tone	____________

ANTICIPATORY GUIDANCE

Diet – Type Recommended

☐ Breastfeeding
☐ Maternal diet/Vitamins
☐ Use of Vitamins
☐ No Solids

☐ Bathing / Water temp
☐ Smoke Detectors
☐ Formula quantity/Mixing
☐ Fall prevention

Development

☐ Stimulation/Music
☐ Comforting/Holding
☐ Rest for mother

Injury Prevention

☐ Need & Use of Car Seat
☐ Sibling Safety

Medical Education

☐ Sleep position - Back
☐ Signs of illness
☐ Temp taking
☐ No bottle propping
☐ Cord care
☐ Skin care
☐ Telephone calls
☐ Other ______________

____

LABS: ☐ Repeat neonatal screen ☐ Other ______________

IMMUNIZATIONS: ☐ Hep B #1, if not done in hospital

☐ Vaccine Information Sheet given & discussed

Vaccine Concerns? ☐ No ☐ Yes: Resolved Deferred Refused

Comments ____________________________________

If vaccines refused, form signed? ☐ No ☐ Yes

ASSESSMENT/RECOMMENDATIONS:

☐ Healthy newborn ____________________________

____

____

____

☐ Return for 2 month checkup

______________________, M.D.

SICK VISIT – Mod 25
CC:

HPI:

MDM:

>50% of ________ min visit spent counseling