# SOUTHLAKE PEDIATRICS
# HEALTH SUPERVISION VISIT 4 MONTHS

Name: ______________________________ DOB: __________

Date of Visit ___________________________ Age __________

Parental Language Barrier: ☐ N ☐ Y ____________________

## PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

☐ No Concerns

______________________________________________

______________________________________________

______________________________________________

## PAST MEDICAL HISTORY

Allergies________________ Immunization reactions__________

Other______________________________________________

______________________________________________

______________________________________________

## PRESENT HISTORY

Medications: ______________________________________

Diet & Feeding: ☐ Breast ☐ Bottle ______________formula

______________________________________________

Bowel movements ______________________________

Sleep ____________________________________________

## DEVELOPMENT

Follows 180° ________________ Laughs ______________

Reaches ________________ Holds rattle________________

Rolls over ______________ Prone-lifts head & body __________

## SOCIAL/FAMILY

Child Care ________________________________________

Family Stresses ____________________________________

______________________________________________

Smoke Exposure ____________________________________

Siblings___________________________________________

Other _____________________________________________

______________________________________________

______________________________________________

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/Strabismus | ______________ |
| ☐ | ☐ | Ears/Nose/Oropharynx | ______________ |
| ☐ | ☐ | Neck/Nodes | ______________ |
| ☐ | ☐ | Chest/Lungs | ______________ |
| ☐ | ☐ | Cardiovascular/Pulses | ______________ |
| ☐ | ☐ | Abdomen | ______________ |
| ☐ | ☐ | Genitalia | ______________ |
| ☐ | ☐ | Musculoskeletal/Hips | ______________ |
| ☐ | ☐ | Neuro/Reflexes | ______________ |
| ☐ | ☐ | Hearing | ______________ |
| ☐ | ☐ | Vision | ______________ |

## ANTICIPATORY GUIDANCE

**Diet**

☐ Continue Breast/formula

☐ Starting solids/one new food at a time

**Development**

☐ Plays on tummy

☐ Toys- rattle, spoon, cup, ball

☐ Talking to baby

☐ Plays games/peek-a-boo/ so-big/repetition

**Injury Prevention**

☐ Car Seat

☐ Burn Prevention

☐ Smoke Detectors

☐ No walker

☐ Fall prevention

**Medical Education**

☐ Review immunizations

☐ Acetaminophen dose

☐ Anticipate teething

☐ No smoking

☐ Telephone

**IMMUNIZATIONS:** ☐ DTaP ☐ IPV ☐ HIB ☐ Prevnar

☐ Rotateq ☐ Other______________________________

☐ Vaccine Information Sheet given & discussed

Vaccine concerns? ☐ No ☐ Yes: Resolved Deferred Refused

Comments______________________________________

If vaccines not given, form signed? ☐ No ☐ Yes

## ASSESSMENT/RECOMMENDATIONS

☐ Healthy infant__________________________________

______________________________________________

______________________________________________

☐ Return for 6 month checkup

________________________, M.D.

SICK VISIT – Mod 25

CC:

HPI:

MDM:

>50% of ________min visit spent counseling