Name_____ DoB ___/___/___ Seen with: ☐ Mth. ☐ Fth. ☐ Other _____

History (Interval: ☐ No Change) Drug Allergies ☐ Yes ☐ No

☐ Breast ☐ Formula

Current Meds:

Past Medical / Family / Social (Interval: ☐ No Change)

☐ Full term ☐ Premature (# weeks_____) Birth Wt._____ Disch. Wt._____

Apgar _____ Metab. Screen ☐ Nl ☐ Abn Hear. Screen ☐ Nl ☐ Abn

Hx. reviewed by _____

Procedures ☐ Hepatitis B

Physical Exam ☑ Nl ☒ Abn *Describe abn. and pertinent nl. findings*

1. ☐ Gen. App. · Temp____ Pulse____ Resp____ Head Circ.____/____%
2. ☐ Head / Face / Neck - fontanelle
3. ☐ Eyes - red reflex, appears to see
4. ☐ ENMT - appears to hear
5. ☐ Respiratory
6. ☐ Cardiovascular - femoral pulses
7. ☐ Chest (breasts, axillae)
8. ☐ Abd / Gastro
9. ☐ Genitalia (male-testes down), Groin, Buttocks
10. ☐ Genitourinary
11. ☐ Hem / Lymph
12. ☐ Integumentary
13. ☐ Back / Mus-Skel - hips
14. ☐ Neurological / Psychiatric

Assessment / Plan ☐ Normal Exam. ☐ Basic instructions provided

Provider Signature _____ Next Visit _____

Anticipatory Guide ☐ Gr/Dev ☐ Vit/Nutrition - no honey ☐ Sleep (supine) ☐ No microwave ☐ No shaking ☐ Home safety ☐ Carseat ☐ Ed. handouts

Birth to 1mo	Date / Time	Age	Wt / %	Ht / %	Summary

☐ Referral

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Name_____ Today's Date ___/___/___

SECTION TO BE COMPLETED BY PARENT

Personal / Social History

Are you concerned about your baby's…	Yes	No
1. feedings ☐ Breast ☐ Formula	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining or crying with voiding	☐	☐
5. nasal stuffiness	☐	☐
6. skin color or skin rashes *(circle)*	☐	☐
7. excessive crying	☐	☐
8. body movements, especially extremities	☐	☐
9. lack of response to your face or blink at light	☐	☐
10. lack of response to a loud noise	☐	☐
11. sleep habits	☐	☐
12. Does he/she sleep on back?	☐	☐
13. Does he/she ride in a rear-facing safety seat?	☐	☐
14. Does he/she live in a smoke-free home?	☐	☐
15. Are you getting enough rest?	☐	☐
16. Have you been sad, depressed or crying a lot?	☐	☐
17. Do you know infant CPR?	☐	☐

Birth History

Maternal

	Yes	No
Were there complications during pregnancy?	☐	☐
Were there complications during labor?	☐	☐
Were there complications during delivery?	☐	☐

Newborn

	Yes	No
Did your baby have complications?	☐	☐

Parent Comments

Do you have concerns you wish to discuss? Y☐ N☐

Parent's Sig _____

Provider Comments ☐ Addressed problems from previous visits

☐ Reviewed consultations, lab / x-ray, hospital reports, etc.

Provider Signature _____

