

Well Child Exam

Infancy: 0-4 weeks



0-4 weeks

Date									
Patient Name				DOB		Sex		Parent Name	
Allergies					Current Medications				
Prenatal / Family History							Ethnicity		
Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				
Birth History									
Birth Wt: _____ Apgar: _____ Gestation: _____ <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section Complications <input type="checkbox"/> Y <input type="checkbox"/> N									

Interval History
(include injury/illness, visits to other health care providers, changes in family or home) _____ _____
Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Monitor
Nutrition
<input type="checkbox"/> Breast every _____ hours <input type="checkbox"/> Formula _____ oz. every _____ hours With iron Y <input type="checkbox"/> N <input type="checkbox"/> Type or brand _____ <input type="checkbox"/> City water <input type="checkbox"/> Well water
Elimination
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal # of stools/day _____
Sleep
<input type="checkbox"/> Normal (2-4 hours) <input type="checkbox"/> Abnormal
Screening
Hearing <input type="checkbox"/> Responds to sounds <input type="checkbox"/> Neonatal ABR or OAE results in chart
Vision <input type="checkbox"/> Looks at faces <input type="checkbox"/> Parental observation/concerns
Neonatal Metabolic Screen in Chart <input type="checkbox"/> Y <input type="checkbox"/> N Test date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Today
Immunizations
HepB Given in Hospital? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Today _____ <input type="checkbox"/> Immunizations Reviewed, Given & Charted – <i>if not given, document rationale</i> <input type="checkbox"/> M CIR checked/updated
<input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page
WIC <input type="checkbox"/> Y <input type="checkbox"/> N ISS <input type="checkbox"/> Y <input type="checkbox"/> N
Developmental Questions and Observations on Page 2
Next Well Check: 2 months of age
Provider Signature:

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N		
Review of Symptoms	Physical Exam	Systems
N A	N A	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	General appearance
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Head
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Eyes
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Ears
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Nose
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Oropharynx
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Gums/palate
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Neck
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Lungs
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Heart/pulses
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Abdomen
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Genitalia
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Spine
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Extremities/hips
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Neurological
<input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page		
Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N		
Plan		
<input type="checkbox"/> History/Problem List/Meds Updated		
<input type="checkbox"/> Referrals		
<input type="checkbox"/> WIC <input type="checkbox"/> Head Start <input type="checkbox"/> Transportation		
<input type="checkbox"/> Children Special Health Care Needs		
<input type="checkbox"/> Priority Health Case Mgmt 800 998-1037		
<input type="checkbox"/> Other _____		

Anticipatory Guidance / Health Education (√ if discussed)
Healthy and Safe Habits
Injury and Illness Prevention
<input type="checkbox"/> Appropriate car seat placed in back seat <input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Keep hot liquids away from baby <input type="checkbox"/> Smoke detectors, household smoking <input type="checkbox"/> Crib safety/safe sleep <input type="checkbox"/> Put baby to sleep on back <input type="checkbox"/> Don't leave baby alone in tub or high places; always keep hand on baby <input type="checkbox"/> Water temp. <120 degrees/test with wrist <input type="checkbox"/> Child-proof home <input type="checkbox"/> Appropriate infant supervision <input type="checkbox"/> Never shake baby <input type="checkbox"/> Avoid direct sun <input type="checkbox"/> Know signs of illness <input type="checkbox"/> Emergency procedures, CPR
Nutrition
<input type="checkbox"/> Hold baby when feeding <input type="checkbox"/> Breast on demand or feed iron-fortified formula <input type="checkbox"/> Don't put cereal in bottle <input type="checkbox"/> Delay solid foods until 4-6 months <input type="checkbox"/> Don't warm bottles in microwave
Oral Health
<input type="checkbox"/> Don't put baby to bed with bottle
Infant Care
<input type="checkbox"/> Thermometer use; antipyretics <input type="checkbox"/> Skin/nail care; bathing; elimination <input type="checkbox"/> Pacifiers, thumb sucking <input type="checkbox"/> Sleeping <input type="checkbox"/> Colic/crying <input type="checkbox"/> Cord care
Parent-Infant Interaction
<input type="checkbox"/> Look, listen, and smile at baby <input type="checkbox"/> Learn baby's temperament <input type="checkbox"/> Console, hold, cuddle, rock, play w/baby <input type="checkbox"/> Talk, sing, play music, and read to baby
Family Support and Relationships
<input type="checkbox"/> Encourage partner to help care for infant <input type="checkbox"/> Take time for self and spend time alone with your partner <input type="checkbox"/> Keep in contact with friends, family <input type="checkbox"/> Postpartum check-up <input type="checkbox"/> Family planning <input type="checkbox"/> Substance abuse, domestic violence, depression
Community Interaction
<input type="checkbox"/> Consider parenting classes <input type="checkbox"/> Discuss child care, returning to work

Date	Patient Name	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the infant:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Please tell me any concerns you have about the way your baby is behaving or developing:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby looks at me and listens to my voice. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby calms down when picked up. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby is sleeping well. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby is eating well, sucking well. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby can hear sounds. |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby looks at my face. |

Ask the parent to respond to the following statements:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | I am sad more often than I am happy. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have more good days with my baby than bad days. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have people who help me when I get frustrated with my baby. |

Provider to follow up as necessary.

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Infant Development			Parent Development		
Cries, coos, and smiles	Yes	No	Looks at infant	Yes	No
Infant responds to soothing	Yes	No	Picks up and soothes infant	Yes	No
Infant listens to voices	Yes	No	Listens to infant	Yes	No
Infant fixates on human face, follows with eyes to midline	Yes	No	Talks to infant	Yes	No
Lifts head momentarily	Yes	No	Touches infant	Yes	No
Moves arms, legs, and head	Yes	No			

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional notes from pages 1 and 2:

Family History Update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who _____ what age _____
- New medical diagnosis: who _____ what age _____
- Anything else in your family history you have concerns or questions with: (Refer to Family History form)

Staff Signature: _____ **Provider Signature:** _____

Patient Education:

Your Baby's Health at 0-4 Weeks

Milestones: Ways your baby is developing between 2 weeks and 2 months

- Looks at your face when you hold him/her, follows you as you move
- Pays attention to your voice
- Shows he/she hears sounds by startling, blinking, or crying
- Moves arms and legs, tries to lift head when lying on tummy
- Tells you what he/she needs by fussing or crying

Safety Tips

- Use a rear-facing car seat for your baby on every ride. Buckle your baby up in the back seat, away from the air bag.
- NEVER shake your baby. Shaking can cause very serious brain damage. Make sure everyone who cares for your baby knows this.

Health Tips

- Learn to know when your baby is hungry, so you can feed him/her before he/she cries. Your baby may get fussy or turn their head toward your body when you hold them.
- *Breast milk is the perfect food for babies for at least the first year. Keep breast-feeding as long as possible.*
- If you are giving your baby a bottle, hold them in your arms during feedings. Your baby needs this special time with you.
- Immunizations ("Shots") protect your baby from 12 very serious diseases. Make sure your baby gets all of his/her shots on time.
- To lower the chance of your baby dying from Sudden Infant Death Syndrome (SIDS), ALWAYS put your baby to sleep on his/her back in a crib or bassinet. Nothing else should be in the crib or bassinet. There should be no soft bedding, blankets, pillows, or toys in the crib or bassinet.
- Keep your baby away from people who have colds and coughs. Make sure that people who hold or care for your baby wash their hands often.
- Call your baby's doctor or nurse before your next visit if you have any questions or worries about your baby.

Parenting Tips

- Help your baby learn new skills by playing with him/her.
- Give your baby the gift of your attention. Take lots of time to hold him/her, look into his/her eyes, and talk softly. Your baby can see and hear you. He/she is already learning!
- Comfort your baby when he/she cries. Your baby fusses and cries to try to tell you what he/she wants. Holding will not spoil him/her.
- When you are a parent you will be happy, mad, sad, frustrated, angry, and afraid, at times. This is normal. If you feel very mad or frustrated:
 - o Make sure your child is in a safe place (like a crib) and walk away.
 - o Call a good friend to talk about what you are feeling.
 - o Call the Parent Helpline at 800 942-4357 (in Michigan). It's free! They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

For Help or More Information

Priority Health

Customer Service 616 942-1221 or 800 446-5674

Medicaid 888 975-8102

Behavioral Health 616 464-8500 or 800 673-8043

priorityhealth.com

Depression

Surrounding pregnancy and childbirth

www.depressionafterdelivery.com/Home.asp

Domestic Violence

National Domestic Violence Hotline

800 799-SAFE (7233)

Breastfeeding, Food and Health Information

Women, Infant, and Children (WIC) Program

800 262-4784

The National Women's Health Information Center Breastfeeding Helpline

800 994-WOMAN (9662) *www.4woman.gov/breastfeeding*

LA LECHE League 847 519-7730 *www.lalecheleague.org*

Special Health Care Needs

Children Special Health Care Services, MDCH Family 800 359-3722

Car Seat Safety

Auto Safety Hotline 888 327-4236

Childhood Development

Early On Michigan 800 327-5966

Michigan Head Start Association 517 374-6472