

# Well Child Exam

Infancy: 2 months



# 2 months

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 <input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page
Screening
<b>Hearing</b> <input type="checkbox"/> Responds to sounds <input type="checkbox"/> Neonatal ABR or OAE results in chart
<b>Vision</b> <input type="checkbox"/> Looks at faces <input type="checkbox"/> Parental observation/concerns
<b>Neonatal Metabolic Screen in Chart</b> <input type="checkbox"/> Y <input type="checkbox"/> N Test date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Today
Immunizations
<input type="checkbox"/> Immunizations Reviewed, Given & Charted – <i>if not given, document rationale</i> <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB <input type="checkbox"/> Hib <input type="checkbox"/> PCV <input type="checkbox"/> MCLR checked/updated <input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours
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: 4 months of age
Provider Signature:

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N		
Review of Symptoms	Physical Exam	Systems
<b>N</b> <b>A</b>	<b>N</b> <b>A</b>	
<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"/> ISS <input type="checkbox"/> Early On <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/cigarettes away from baby <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"/> Wash hands often/clean toys <input type="checkbox"/> Put baby to sleep on back <input type="checkbox"/> Don't use soft bedding or toys in sleep area <input type="checkbox"/> Never shake baby <input type="checkbox"/> Know signs of illness <input type="checkbox"/> Emergency procedures home, child care
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 <input type="checkbox"/> Practice good family oral health habits
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
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"/> Meet needs of other children <input type="checkbox"/> Family planning <input type="checkbox"/> Substance abuse, domestic violence, depression
Community Interaction
<input type="checkbox"/> Parenting classes/support group <input type="checkbox"/> Discuss child care, returning to work, play group

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
- Please tell me any concerns you have about the way your baby is behaving or developing:
- \_\_\_\_\_
- My baby looks at me and listens to my voice.
- My baby quiets when picked up.
- My baby is sleeping well.
- My baby is eating well, sucking well.
- My baby makes cooing sounds.
- My baby lifts his/her head while on tummy.

Ask the parent to respond to the following statements:

- Yes      No
- I am sad more often than I am happy.
- I have more good days with my baby than bad days.
- 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		
Coos and vocalizes reciprocally*	Yes	No	Looks at infant	Yes	No
Smiles responsively	Yes	No	Picks up and soothes infant or comforts baby effectively	Yes	No
Follows to midline	Yes	No	Are parent and baby interested in and responsive to each other?	Yes	No
Is attentive to voices, sounds, visual stimuli	Yes	No	Does parent seem depressed, angry, tired, overwhelmed, or uncomfortable?	Yes	No
Some head control in upright position	Yes	No			
Shows pleasure interacting w/parent	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:

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**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 2 months

#### Milestones: Ways your baby is developing between 2 and 4 months of age

- Likes to look at and be with familiar people
- Shows excitement by waving arms and legs and smiles when you speak to him/her
- Eyes follow people and things
- Lifts head and shoulders up when lying on tummy
- Babbles and coos; smiles/laughs/squeals
- Likes toys that make sounds and tries to hold small toys
- Holds his/her own hands and feet

#### 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 causes serious brain damage. Make sure everyone who cares for your baby knows this.

#### Preventing burns:

- Check to make sure the bath water is lukewarm, not hot, before you put your baby in the water.
- Avoid drinking hot coffee, tea, or other drinks while holding your baby.
- Keep your baby out of the sun. Dress your baby in a hat with a brim and clothes that cover the arms and legs.

#### Health Tips

- “Well child” check-ups help keep your baby healthy. Try not to miss these doctor visits. If you do, call for another appointment.
- Keep your baby's immunization (shot) card in a safe place and bring it to every doctor or clinic visit.
- Breast milk or formula is all that babies this age need to grow. Avoid giving juice to your baby at this age. Sometimes your baby will need to eat more often than other times. This means he/she is growing faster.
- You can keep breastfeeding when you go back to work. For information, talk to your doctor or nurse or call WIC.
- Keep your baby away from people who are smoking. Tobacco smoke may cause your baby to be sick with breathing problems or ear infections, and may increase the chance of Sudden Infant Death Syndrome (SIDS).
- Continue putting your baby to sleep on his/her back to lower the chance of SIDS. Make sure grandparents and other baby sitters also put your baby to sleep on his/her back.
- Call your baby's doctor or nurse before your next visit if you have any questions about your baby's health, growth, or development.

#### Parenting Tips

- Help your baby learn and grow by playing lovingly with him/her.
- Talk and sing to your baby and look into his/her eyes. This helps your baby know you love him/her and helps his/her brain grow.
- 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