

Name _____		BIRTH DATE _____	AGE _____	ACCOMPANIED BY/INFORMANT _____	PREFERRED LANGUAGE _____
		<input type="checkbox"/> M <input type="checkbox"/> F			
ID NUMBER _____	CURRENT MEDICATIONS See other side for current medication list		DRUG ALLERGIES _____		
WEIGHT (%) _____	LENGTH (%) _____	WEIGHT FOR LENGTH (%) _____	HEAD CIRC (%) _____	TEMPERATURE _____	DATE/TIME _____

See growth chart.

**BF = Bright Futures Priority Item**

**History**

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<input type="checkbox"/> Term or _____ weeks Birth weight _____ Discharge weight _____ Newborn hearing screening <input type="checkbox"/> Normal <input type="checkbox"/> Pending results <input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal _____ Newborn blood spot screen <input type="checkbox"/> Normal <input type="checkbox"/> Pending results <input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal _____	Blood type: Maternal _____ Infant _____ Direct Coombs _____ Bilirubin screening <input type="checkbox"/> None Transcutaneous bilirubin _____ Serum bilirubin _____ Hep B (maternal): <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Hep B vaccine ____ / ____ / ____ Comments _____ _____ _____
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Home birth    Previsit Questionnaire reviewed

**BF** Concerns / questions raised by \_\_\_\_\_  None  Addressed (see other side)

**BF** Follow-up on previous concerns \_\_\_\_\_  None  Addressed (see other side)

**BF**  Medication Record reviewed and updated

**Social/Family History**

**Family situation**    Single Parent

**BF** Parent adjustment to new child \_\_\_\_\_

**BF** Maternal Depression  Yes  No \_\_\_\_\_

PHQ 9                       Pass               Refer

PHQ 2                       Pass               Refer

Edinburgh                 Pass               Refer

**BF** Reaction of siblings to new child \_\_\_\_\_

**BF** Work plans \_\_\_\_\_

**BF** Child care plans \_\_\_\_\_

Heat source \_\_\_\_\_

**BF**  Tobacco Exposure

**Review of Systems**

= NL

Date of last visit \_\_\_\_\_

Changes since last visit \_\_\_\_\_

**Nutrition:**    Breast milk                      Minutes per feeding \_\_\_\_\_  
                     Hours between feeding \_\_\_\_\_ Feedings per 24 hours \_\_\_\_\_  
                     Problems with breastfeeding \_\_\_\_\_  
                      Formula                                      Ounces per feeding \_\_\_\_\_  
                     Source of water \_\_\_\_\_ Vitamins/Fluoride \_\_\_\_\_

**Elimination:**  NL \_\_\_\_\_

**Sleep:**    NL \_\_\_\_\_

**Behavior:**  NL \_\_\_\_\_

**Development** (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL *Eats well	<input type="checkbox"/> COMMUNICATIVE *Turns and calms to your voice
<input type="checkbox"/> PHYSICAL DEVELOPMENT *Can suck, swallow, and breathe easily	<input type="checkbox"/> COGNITIVE *Follows your face

(see other side for plan, immunizations and follow-up)

**Physical Examination**

= Reviewed w/Findings                      **OR**                       NL = Reviewed/Normal

GENERAL APPEARANCE \_\_\_\_\_  NL

**BF**  SKIN (rashes, jaundice) \_\_\_\_\_  NL

**BF**  HEAD / FONTANELLE \_\_\_\_\_  NL

**BF**  EYES (red reflex/strabismus/appears to see) \_\_\_\_\_  NL

EARS/APPEARS TO HEAR \_\_\_\_\_  NL

NOSE \_\_\_\_\_  NL

MOUTH AND THROAT \_\_\_\_\_  NL

NECK \_\_\_\_\_  NL

LUNGS \_\_\_\_\_  NL

**BF**  HEART \_\_\_\_\_  NL

**BF**  FEMORAL PULSES \_\_\_\_\_  NL

**BF**  ABDOMEN (umbilical cord, vessels) \_\_\_\_\_  NL

HERNIA \_\_\_\_\_  NL

GENITALIA \_\_\_\_\_  NL

Male/Testes down \_\_\_\_\_  NL

Female \_\_\_\_\_  NL

CIRCUMCISION \_\_\_\_\_  NL

**BF**  NEUROLOGIC (tone, symmetry, state regulation) \_\_\_\_\_  NL

EXTREMITIES \_\_\_\_\_  NL

**BF**  MUSCULOSKELETAL (torticollis) \_\_\_\_\_  NL

**BF**  HIPS \_\_\_\_\_  NL

NO DYSMORPHISMS \_\_\_\_\_  NL

HYGIENE \_\_\_\_\_  NL

BACK \_\_\_\_\_  NL

**BF** Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Assessment**

**BF**  Well Child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Anticipatory Guidance**

= Discussed and/or handout given

Identified at least one child and parent strength

Raising Readers book given

<input type="checkbox"/> NEWBORN TRANSITION	<input type="checkbox"/> NUTRITIONAL ADEQUACY	<input type="checkbox"/> SAFETY
<ul style="list-style-type: none"> <li>• Back to sleep</li> <li>• Daily routines</li> <li>• Calming techniques</li> </ul>	<ul style="list-style-type: none"> <li>• Breastfeeding (vitamin D supplement)</li> <li>• Iron-fortified formula (if not breastfed)</li> <li>• No solid foods</li> <li>• No honey; no Karo syrup</li> </ul>	<ul style="list-style-type: none"> <li>• Car safety seat (infant rear facing)</li> <li>• Smoke-free environment</li> <li>• No shaking</li> <li>• No shaking</li> <li>• Burns</li> <li>• Water heater</li> <li>• Smoke detectors</li> <li>• Crib safety</li> <li>• Sun safety</li> </ul>
<input type="checkbox"/> NEWBORN CARE	<input type="checkbox"/> PARENTAL WELL-BEING	
<ul style="list-style-type: none"> <li>• Emergency preparedness plan</li> <li>• Frequent hand washing</li> <li>• Avoid direct sun exposure</li> <li>• Expect 6-8 wet diapers/day</li> </ul>	<ul style="list-style-type: none"> <li>• Baby blues</li> <li>• Accept help</li> <li>• Sleeps when baby sleeps</li> <li>• Unwanted advice</li> </ul>	

