### History

- **BF** □ Previsit Questionnaire reviewed □ Child has special health care needs
- 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

- BF □ Family situation
  - □ Single Parent
- BF □ Parental support/work/family balance
  - Maternal Depression □ Yes □ No
  - PHQ 9 □ Pass □ Refer
  - PHQ 2 □ Pass □ Refer
  - Edinburgh
- BF □ Parents working outside home: □ Mother □ Father
- BF □ Child care: □ Yes □ No □ Type __________
- BF □ Changes since last visit
- BF □ Tobacco Exposure

### Review of Systems

- □ = NL
- Date of last visit
  - Changes since last visit
  
  - Nutrition: □ Breast milk Minutes per feeding ______
    - □ Hours between feeding _______ Feeding per 24 hours ______
    - □ Problems with breastfeeding
    - □ Formula Ounces per feeding ______
    - □ Solid foods _______ Source of water ______
  - Vitamins/Fluoride/Elimination: □ NL ________
  - Sleep: □ NL ________
  - Behavior: □ NL ________

### Physical Examination

- □ = Reviewed w/Findings OR □ NL = Reviewed/Normal
- □ GENERAL APPEARANCE ______
- □ SKIN (rashes, bruising) ______
- BF □ HEAD / FONTANELLE (positional skull deformities) ______
- BF □ EYES (red reflex/strabismus/appears to see) ______
  - □ EARS/APPEARS TO HEAR ______
  - □ NOSE ______
  - □ MOUTH AND THROAT ______
  - □ NECK ______
  - □ LUNGS ______
  - BF □ HEART ______
- BF □ FEMORAL PULSES ______
- □ ABDOMEN ______
- □ HERNA ______
- □ GENITALIA ______
  - Male/Testes down □ Female
- BF □ NEUROLOGIC / GAIT (tone, strength, symmetry) ______
- □ EXTREMITIES ______
- BF □ MUSCULOSKELETAL (torticollis) ______
- BF □ HIPS ______
- □ NO DYSMORPHISMS ______
- □ HYGIENE ______
- □ BACK ______
- 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
  - Describe immunization side effects & when to call

- BF □ FAMILY FUNCTIONING ______
- BF □ NUTRITIONAL ADEQUACY AND GROWTH ______
  - Breastfeeding (vitamin D, iron supplement) ______
  - Iron-fortified formula ______
  - Solid foods ______
  - When and how to add ______
  - Weight gain and growth spurts ______
  - Elimination ______

- BF □ INFANT DEVELOPMENT ______
  - Social development ______
  - Communication skills ______
  - Physical (tummy time) ______
  - Daily routines ______
  - Sleep ______
  - ORAL HEALTH ______
  - Don’t share utensils/pacifier ______
  - Avoid bottle in bed ______

- BF □ SAFETY ______
  - Car safety seat (infant rear facing) ______
  - Falls ______
  - Burns ______
  - Hot liquids ______
  - Water heater ______
  - Walkers ______
  - Drowning ______
  - Choking ______
  - Lead Poisoning ______
  - Sun Safety ______
# WELL CHILD VISIT

## Plan

**BF**: Patient is up to date, based on CDC/ACIP immunization schedule.
- If no, immunizations given today.
- Immun Pac2 record reflects current immunization status:
  - Yes
  - No

**Oral Health**
- Oral health risk assessment
  - Completed
  - Low
  - Mod
  - High
- Has a dental home
- Dental fluoride varnish applied
- Well water testing
  - Yes
  - No

**MaineCare Member Support Requested**
- Transportation to appointments
- Find dentist
- Find other provider
- Make doctor’s appointment
- Public Health Nurse referral
- Family aware

**Laboratory/Screening results**

**Hearing screen**
- Previously done
- Date completed

**BF Referral to**

**BF Follow-up/Next Visit**

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**Narrative Notes:**

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**EXAMINER’S SIGNATURE**

**DATE**