Two Months

WELL CHILD VISIT

Revised August 2020

Name	BIRTH DATE	AGE	ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE
		❑M ❑F		

ID NUMBER	CURRENT MEDICATIONS	DRUG ALLERGIES
	See other side for current medication list	

WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	DATE/TIME

See growth chart.

BF = Bright Futures Priority Item

History

BF ❑ Previsit Questionnaire reviewed
BF ❑ Child has special health care needs
Newborn Screening ❑NL
Hearing Screening ❑NL

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 Parent adjustment to child _____

BF Maternal Depression ❑ Yes ❑ No _____

PHQ 9	❑ Pass	❑ Refer
PHQ 2	❑ Pass	❑ Refer
Edinburgh	❑ Pass	❑ Refer

BF Parents working outside home: ❑ Mother ❑ Father

BF Child care: ❑ Yes ❑ No Type _____

BF Changes since last visit _____

Heat source _____

BF ❑ Tobacco Exposure

Review of Systems

BRIGHT FUTURES

☑ = 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)

❑ PHYSICAL DEVELOPMENT
*Lifts head and begins to push up when prone
*Holds head erect for short periods (when held upright)
*Diminished newborn reflexes
*Symmetrical movement

❑ COMMUNICATIVE
*Coos
*Different cries for different needs

❑ COGNITIVE
*Indicates boredom when no activity change

❑ SOCIAL-EMOTIONAL
*Smiles
*Looks at parent
*Self-comfort

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

Physical Examination

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

❑ GENERAL APPEARANCE _____ ❑NL
BF ❑ **SKIN (rashes, bruising)** _____ ❑NL
BF ❑ **HEAD / FONTANELLE (positional skull deformities)** _____ ❑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
❑ ABDOMEN _____ ❑NL
❑ HERNIA _____ ❑NL
❑ GENITALIA _____ ❑NL
❑ Male/Testes down _____ ❑NL
❑ Female _____ ❑NL
BF ❑ **NEUROLOGIC / GAIT (tone, strength, symmetry)** _____ ❑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 Reader book given
❑ Describe immunization side effects & when to call

BRIGHT FUTURES

❑ PARENTAL (MATERNAL) WELL-BEING
❑ INFANT-FAMILY SYNCHRONY
❑ NUTRITIONAL ADEQUACY
- Breastfeeding (400 IU vitamin D supplement)
- Iron-fortified formula
- Solid foods (wait until 4-6 months)
- Elimination
- No bottle in bed

❑ INFANT BEHAVIOR
- Calming skills
- Physical
  - Tummy time
  - Daily routines
- Sleep
  - Back to sleep

❑ SAFETY
- Car safety seat (infant rear facing)
- Falls
- Burns
  - Hot liquids
  - Water heater
- Smoke-free environment
- Drowning
- Choking
  - Small objects
  - Plastic bags
  - Sun Safety

Two Months WELL CHILD VISIT

NAME	Male / Female	Medical Record Number	DOB Actual age (weeks): O 7 O 8 O 9 O 10

Current Medications _____

_____

_____

Plan

BF Patient is up to date, based on CDC/ACIP immunization schedule. ❑Yes ❑No

If no, immunizations given today. ❑Yes ❑No

ImmPact2 record reflects current immunization status: ❑Yes ❑No

_____

_____

❑ Immunization plan/comments _____

_____

_____

❑ Ask about WIC

BF Laboratory/Screening results _____

_____

_____

_____

Hearing screen _____

❑Previously done Date completed _____

Newborn blood spot screen _____

❑Previously done Date completed _____

MaineCare Member Support Requested

❑ Transportation to appointments

❑ Find dentist

❑ Find other provider

❑ Make doctor's appointment

❑ **Public Health Nurse referral**

❑ Family aware

_____

_____

_____

_____

_____

BF Referral to _____

_____

BF Follow-up/Next Visit _____

_____

Narrative Notes:

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EXAMINER'S SIGNATURE	DATE

STATE OF MAINE
Department of
Health and Human Services