Name: FMP/SSN last four: DOB:
Appointment Date: Contact Number:

4 - 11 MONTH VISIT

Do you have any specific concerns today? ____
____
____

Any recent ER visits? ❑Yes ❑ No **When:** ______________ **Reason:**____

*****_**(Please complete information below: If filled out before, list only changes since the last visit.)**_*****

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
		Allergies **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** ❑ Infant Multivitamin 1 ml per day ❑ Vit D 400 IU 1 drop per day

Circle if anyone in the family has had: Genetic or Metabolic Disease / Birth Defects / Kidney Disease / Deafness < 5 years old
Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Please list any known allergies your child has (drug, food, latex) ______________________________________

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No
Is the child's sponsor currently deployed? ❑Yes ❑ No **Is this visit deployment related**? ❑ Yes ❑ No
Is either of the child's parents on PRP status? ❑Yes ❑ No
Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure
Who does your child live with? ____
Does your child attend daycare? ❑ Yes ❑ No
Does anyone in the family smoke? ❑ Yes ❑ No
Do you & your child feel safe at home? ❑ Yes ❑ No
What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: ________________________
Preferred language: ❑ English ❑ Other: ___________
Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No ____________________

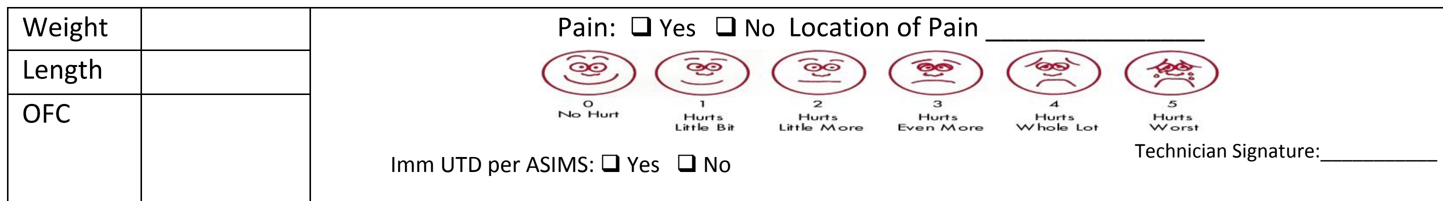
Birth History: (if not completed before)

 # weeks pregnant at delivery? ______
Type of Delivery (check all that apply): ❑ Vaginal ❑ Forceps ❑ Vacuum-assisted ❑ C-section ❑ Breech
Complications at birth? ____
Prenatal complications? ❑ Yes ❑ No List:____
Group B Strep positive? ❑ Yes ❑ No ❑ Don't Know
Baby's hearing screen normal? ❑ Yes ❑ No ❑ Not performed

Breastfeeding? ❑ Yes ❑ No **How often?** ________ **Minutes per breast**?______ **Concerns?**____________________
Bottle feeding? ❑ Yes ❑ No **Brand?** _____________ **Ounces per feed?** _________ **Ounces per day?** ________________
Cereal? ❑ Yes ❑ No **How many times per day?** _____ **Solid foods?** ❑ Yes ❑ No **How many times per day?** _____
Number of wet diapers per day? _____________ **Stools per day?** ____________
Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems / Vision / Hearing

In the age group below that is closest to your child's age, please check the items your child is able to perform

4 MONTH	6 MONTH	9 MONTH
❑ Turns toward voices	❑ Babbles	❑ Sits without help
❑ Head steady when sitting	❑ Responds to name	❑ Crawls
❑ Bears weight on legs	❑ Passes toys from hand to hand	❑ Pulls to a stand
❑ Pushes chest off surface when on tummy	❑ Sits without help if propped	❑ Feeds self with fingers
	❑ Rolls from back to front	❑ Grabs small objects with hands
❑ Brings hands together	❑ Rolls from front to back	❑ Plays Peek-a-Boo
❑ Reaches for objects		❑ Shy with strangers
❑ Laughs		❑ Remembers an object is there if covered



Weight		Pain: ❑ Yes ❑ No Location of Pain ________________
Length		0 No Hurt · 1 Hurts Little Bit · 2 Hurts Little More · 3 Hurts Even More · 4 Hurts Whole Lot · 5 Hurts Worst
OFC		Imm UTD per ASIMS: ❑ Yes ❑ No Technician Signature:___________

HPI:

NE	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT/Nontender/FROM/Fontanelle open & flat/no cleft or pit	□
□	**Eyes:**	□ RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no masses, nl BS, no umbilical/inguinal hernia	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Symmetric skin folds □ Neg Barlow/Ortolani (at 4 months)	□
□	**Neuro:**	□ Normal tone/strength/symmetry	□
□	**Genitalia:**	□ Nl female/no adhesions □ Nl male, Testes down	
□	**Other findings:**	□	□

LABS/X-RAYS: □ Passed hearing screen at birth Metabolic screen: □ Normal □ Abnormal

ASSESSMENT: □ Well baby: normal growth & development for age
□ ASQ performed. Nl development in all areas.

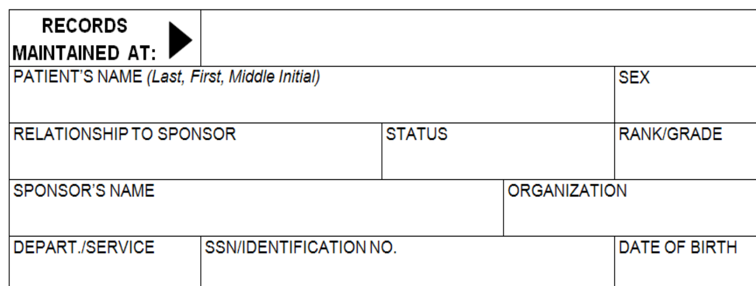
PLAN: ❑ 400 IU Vitamin D supplement/day
❑ Fluoride supplementation (begins at 6 months) as needed locally
❑ Immunizations per clinic schedule

F/U: at next well child visit at ___ months, sooner if parental concerns
□ Patient and/or parent verbalizes understanding of treatment and plan □ Anticipatory guidance handout provided

PREVENTION: □ Nutrition/Solid foods □ Dental care □ Safety/Falls □ Car Seat □ Child-proofing the house □ Tobacco avoidance

Signature:____
Date:
Stamp:

14 June 2012 SF 600



RECORDS MAINTAINED AT: ▶			
PATIENT'S NAME *(Last, First, Middle Initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

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