Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

NEWBORN - 3 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

Who does your baby live with? _____

Does your child attend daycare? ❑ Yes ❑ No ❑ Will start soon

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 at previous visit)

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

Baby received Hepatitis B vaccine at birth? ❑ Yes ❑ No ❑ Don't Know

Baby had newborn genetic/PKU testing performed? ❑ Yes ❑ No ❑ Don't Know

Birth weight? _____

Breastfeeding? ❑ Yes ❑ No How often? _____ Minutes per breast?_____ Concerns?_____

Bottle feeding? ❑ Yes ❑ No Brand? _____ Ounces per feed? _____ Ounces 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

Check all the following that apply to your child:

2 WEEK	2 MONTH	
❑ Responds to voices	❑ Coos/makes noises	❑ Will look from side to side
❑ Fixes on your face	❑ Responds to your voice	❑ Has hands open more than 50% of the time
❑ Moves arms and legs equally	❑ Lift head and chest up when on tummy	❑ Smiles when smiled at
❑ Lift head up when on tummy	❑ Head steady when sitting up	

Weight		Pain: ❑ Yes ❑ No Location of Pain _____
Length		
OFC		Technician Signature:_____ Imm UTD per ASIMS: ❑ Yes ❑No

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	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Neg Barlow/Ortolani	□
□	**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 □ Pending

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

PLAN: ❑ 400 IU Vitamin D supplement/day
❑ 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: □ Back to Sleep □ Safety/Falls □ Breast/bottle feeding □ Tummy Time □ Car Seat
□ For fever, seek care □ 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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