

NAME:
DOB:
GENDER: MALE FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

UNCLOTHED PHYSICAL EXAM

See new patient history form

INTERVAL HISTORY:
NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

3V\FKRVRF LDO %HKDYLR LDF O X GIDOW3R W XHV
SDUWNB UHV VLRQ 6FUHYDQ LGD W H G RMRRO
UHTXLUHG 3'6 33'6 3+4 2)WKHU 3
)LQGLQJV

See growth graph

Weight: _____ (_____ %) Length: _____ (_____ %)
Head Circumference: _____ (_____ %)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

Appearance	Mouth/throat	Genitalia
Head/fontanel	Teeth	Extremities
Skin	Neck	Back
Eyes	Heart/pulses	Musculoskeletal
Ears	Lungs	Hips
Nose	Abdomen	Neurological

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DEVELOPMENTAL 0 (17\$ / + (\$ / 7 + SCREENING:
8VH RI standardized tool \$ 64 3 ('6 3)
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Subjective Vision Screening: P F
Subjective Hearing Screening: P F

NUTRITION*:
Breastmilk
Min per feeding: _____ Number of feedings in last 24 hrs: _____
Formula (type) _____
Oz per feeding: _____ Number of feedings in last 24 hrs: _____
Water source: _____) O X R U L G N
* Solids
See Bright Futures Nutrition Book if needed

HEALTH EDUCATION/ANTICIPATORY GUIDANCE (See back for useful topics)

Selected health topics addressed in any of the following areas*:
 • Family Interaction • Nutrition/Feeding Routine
 • Safety • Infant Development/Behavior

*See Bright Futures for assistance

IMMUNIZATIONS

ASSESSMENT

Up to date Deferred
Reason (if deferred):

Given today: DTaP Hep B Hib IPV
PCV Meningococcal* Hib-Hep B
DTaP-IPV-Hep B DTaP-IPV/Hib , Q À X H Q] D

*Special populations: See ACIP

PLAN/REFERRALS

Referral(s):

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LABORATORY

Tests ordered today:

Signature/title

Signature/title

Name:

Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

9 Month Checkup

- Lead risk assessment*
- Establish consistent bedtime routine
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Provide nap time daily
- Read books and talk about pictures/story using simple words
- Separation anxiety common
- Use distraction or choice of 2 appropriate options for discipline
- Introduce cup and encourage use to begin weaning process
- No bottle in bed
- Slowly increase choice of solids
- Cut table foods small, no hot dogs cut into circles
- Do not leave alone in bath water
- Empty all buckets containing water
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Remove small toys/pins/plastic pieces to allow safe exploration
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No
Ages 6 to 9 months		Turns and looks to you when you are speaking in a quiet voice Waves when you say "bye-bye" Stops for a moment when you say "no-no" Looks at objects or pictures when someone talks about them Babbles song-like tunes Uses voice to get your attention instead of crying Uses different sounds and appears to be naming things