

1 to 14 Day Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

PRENATAL HISTORY

FIRST PRENATAL VISIT DATE	ALCOHOL, AMOUNT	TOBACCO, AMOUNT	STREET DRUGS
STDs (specify)	HEPATITIS B	HIV	OTHER MATERNAL PROBLEMS
WEEKS GESTATION	<input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN	BIRTH WEIGHT	WHERE DELIVERED

PERINATAL HISTORY

DEFORMITIES/APGAR	ABNORMALITIES	OTHER	DATE OF D/C - LOS
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INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

BREAST FORMULA: WIC YES NO REFERRED VITAMINS IRON

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen inc. cord			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (responds to noises, startles) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, Moro reflex)
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

INFANT CAR SEAT "BACK TO SLEEP" OTHER

DIAGNOSIS:
PLAN:
SIGNATURE: