1 - 4 Week Well Exam

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A WellCare Company

Date_____ Patient #_____

Name_____ Date of Birth_____

Address_____

_____

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver

☐ Others (including siblings)_____

_____

May release information to (parent, guardian, other family - list):

_____

_____

Parental concerns: _____

GENERAL HEALTH

Nutrition: ☐ Breast:_____min per _____hrs OR
☐ Formula type_____oz per _____hrs;_____oz/d

Water Source: ☐ City tap ☐ Filtered/bottled
☐ Well
Checked within last 3 mo ☐ Yes ☐ No

Elimination:

YES	NO	
☐	☐	Over 6 wet diapers per day_____
☐	☐	Stooling:_____per day

Problems:_____

Sleep:_____hours through the night

YES	NO	
☐	☐	Place on back to sleep
☐	☐	At night and naps, put to bed awake

Problems:_____

DEVELOPMENT

(Screen or refer if concerns or "No" response on milestones in **bold type)**

YES	NO	
☐	☐	Focuses on faces
☐	☐	Responds to sounds
☐	☐	**Lifts head briefly when in prone**
☐	☐	**Moves arms and legs equally**

Any concerns about development?

_____

MEDICAL HISTORY

Gestational age _____ Maternal labs _____

Complications_____

Birth history: ☐ NSVD ☐ C-section Apgars_____/_____

Breech: ☐ Yes ☐ No

Complications_____

Birth weight_____ D/C weight _____

☐ Passed newborn hearing screen

☐ Neonatal screen done
Results ☐ Pending ☐ Normal ☐ Abn_____

☐ Hepatitis B vaccine given after birth

Major medical illnesses/special healthcare needs

_____

_____

FAMILY HISTORY (circle if present)

Depression or other mental illness, substance use, abuse, learning problems, violence, heart disease, hypertension, diabetes, kidney disease, deafness, cancer
other (note):_____

SOCIAL HISTORY

Child care:_____

FAMILY RISK FACTORS

STRESS:

How much stress are you and your family under now?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?
☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other_____

How stressful is caring for your child?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless?
☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?
☐ No ☐ Sometimes ☐ **Often**

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

☐ Rest and sleep when baby does. Encourage partner/family help
☐ Spend one-on-one time with older siblings and partner

BEHAVIOR:

☐ Follow infant's cues and feed on-demand
☐ "Back to Sleep" and no co-sleeping to prevent SIDS
☐ Calm baby by stroking and gentle rocking; don't shake or hit

NUTRITION/ORAL HEALTH:

☐ Breastfeed at least 8x/24h, vitamin D supplement, no extra water
☐ Discuss mother's medications if breastfeeding
☐ Normal voids- 6-8/24h. Stools vary
☐ If using formula: prepare/store safely, 2-3 oz q 2-4 hrs, hold baby semi-upright, don't prop bottle

SAFETY:

☐ Decrease home water temperature, <120 degrees
☐ If smoking in home: discuss quitting, limiting exposure
☐ Check CO and fire/smoke detectors
☐ Car seat rear-facing until 20 lbs and 1 year old
☐ Child Safety Seat Inspection Locator: 866-732-8243, www.seatcheck.org

NEWBORN CARE:

☐ If fever is 100.4 F (38.0 C) call health provider immediately
☐ Post emergency numbers; know infant CPR
☐ Wash hands prior to handling infant; avoid crowds
☐ Avoid direct sunlight

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MEDICAL HISTORY

Name _____ Date of Birth _____

Allergies _____ Medications _____

Hospitalizations/Surgeries _____

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:_____R:_____T:_____Weight:_____(_____%)

Length _____(_____%) Wt/Length_____% Head circumference _____(_____%)

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	

Results reviewed (outside info, lab, etc.) _____

Impression _____

PLAN OF CARE (see Anticipatory Guidance)

Lab ☐ Bili (if indicated) ☐ Other if indicated ☐ Hip ultrasound at 6 weeks if breech

Developmental Follow-up ☐ No delays ☐ Follow-up in office ☐ Referral

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) _____

Handouts _____

Return appointment _____

Signature _____ Date _____

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