4 Month 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: _____

_____

Changes in child's health since last visit:_____

_____

GENERAL HEALTH

Nutrition: ☐ Breast:_____times/day
☐ Bottle:_____ oz/day
☐ Vitamin D (until 32 oz formula per day)

Elimination: ☐ Stooling: soft, easy to pass BMs

Sleep:_____hours through the night

YES	NO	
☐	☐	Place on back to sleep
☐	☐	Put to bed awake at night and naps
☐	☐	Bottle to bed?

Problems:_____

DEVELOPMENT

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

YES	NO	
☐	☐	**Social smile**
☐	☐	**Coos and laughs interactively**
☐	☐	**Able to be comforted**
☐	☐	**Tracks and follows with eyes**
☐	☐	**Good head control**
☐	☐	**Opens hands, grasps rattle**
☐	☐	**Moves arms and legs equally**
☐	☐	**Lifts head 90 degrees in prone**
☐	☐	May roll over and bear weight on legs

Family concerns about growth, development, behavior

_____

_____

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care:_____

FAMILY RISK FACTORS

Changes in family since last visit:_____

_____

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:
☐ Make time for self, partner, family/friends. Quality child care
☐ Discuss adjustment of older siblings

BEHAVIOR:
☐ Range of infant behaviors and temperaments. Calming strategies
☐ Bedtime and feeding routines enhance sense of security
☐ Teach infant to put self to sleep. Crying won't hurt baby

NUTRITION/ORAL HEALTH:
☐ Solid food readiness, don't share spoon
☐ Ask about supplements, herbs and vitamins
☐ No bottle propping or bottle in bed
☐ Discuss teething and family oral health

SAFETY:
☐ May roll and put things in mouth (small objects, plastic bags)
☐ Discuss lead in home (especially before 1960) and parental occupational hazards - farmers, plumbers, welders
☐ If smoking in home: discuss quitting, limiting exposure

MEDICAL HISTORY

Perinatal problems_____

Newborn screening ☐ Normal ☐ Abn_____

_____

Major medical illnesses/special healthcare needs

_____

_____

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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	
☐	☐	☐	☐	Behavior/interaction with family	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Teeth	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	

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

Impression _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused _____

Lab (if indicated) _____

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 _____

Revised June 2012