



Name: _____

DOB: _____ Actual Age: _____

Language Spoken _____ Interpreter Name _____

Date: _____

1, 2 MONTHS

NURSING INTAKE

Height:	Weight:	H.C.:	Temp.:	Heart Rate:	Resp.:
Allergies:			Growth Charts Completed:		
Abuse:			Notes:		
Alternate health care provider:			MA Signature		

INTERVAL HISTORY

Feedings:	Breastfeed or Bottle	Has WIC: Yes / No
Illnesses:	Sleep position:	TB Risk Yes / No
Stools:	Accidents:	
Vision:	Exposure to tobacco smoke:	
Hearing:	Is mother getting enough sleep? Yes/ No	

GROWTH-DEVELOPMENT

<input type="checkbox"/> Prone, lifts head 45°	<input type="checkbox"/> Follows past midline
<input type="checkbox"/> Vocalizes (cooing)	<input type="checkbox"/> Kicks
<input type="checkbox"/> Smiles responsively (social)	<input type="checkbox"/> Grasps

PARENTAL CONCERNS:

PHYSICAL EXAMINATION

General Appearance <input type="checkbox"/> Well nourished and developed	Heart <input type="checkbox"/> No murmurs, regular rhythm
<input type="checkbox"/> No abuse/neglect evident	Lungs <input type="checkbox"/> Breath sounds normal bilaterally
Head <input type="checkbox"/> Symmetrical, A.F. open _____ cm	Abdomen <input type="checkbox"/> Soft, no masses, liver & spleen normal
Eyes <input type="checkbox"/> Conjunctivae, sclera, pupils normal	Genitalia: Male <input type="checkbox"/> Normal appearance, circ./uncirc.
<input type="checkbox"/> Red reflexes present	<input type="checkbox"/> Testes in scrotum
<input type="checkbox"/> Appears to see <input type="checkbox"/> No strabismus	Female <input type="checkbox"/> No lesions, nl. external appearances
Ears <input type="checkbox"/> Canals clear, TMs normal	Hips <input type="checkbox"/> Good abduction, leg lengths equal
<input type="checkbox"/> Appears to hear	Femoral pulses <input type="checkbox"/> Present and equal
Nose <input type="checkbox"/> Passages patent	Extremities <input type="checkbox"/> No deformities, full ROM
Mouth & pharynx <input type="checkbox"/> Normal color, no lesions.	Skin <input type="checkbox"/> Clear, no significant lesions
Neck <input type="checkbox"/> Supple, no masses palpated	Neurologic <input type="checkbox"/> Alert, moves extremities well

ASSESSMENT:

PLAN:

ORDERS: Vaccine reactions, risks and follow-up explained/VIS sheets

<input type="checkbox"/> DTaP	<input type="checkbox"/> HIB	<input type="checkbox"/> HEP B
<input type="checkbox"/> Nutritional assessment	<input type="checkbox"/> WIC referral	<input type="checkbox"/> Immunization registry entry
<input type="checkbox"/> Rotavirus	<input type="checkbox"/> IPV	<input type="checkbox"/> Prevnar

ANTICIPATORY GUIDANCE: Circle if discussed

Diet: Breast vs. formula feeding, no milk or honey till 1 y/o, no bottle recumbent, feeding position, colic, WIC
 Behavior: Crying, thumb sucking, no discipline yet
 Injury & Violence prevention: Rolling, playpen use, burns from hot liquids, lead poisoning prevention phone number
 Guidance: Fever, acetaminophen dose, hot water temp. 120°, smoking at home, sleeping position
 Safety Precautions: Infant car seat, water safety, falls and window guards, nursery equipment, no smoking, thermometer use, childcare plan, looked cleaning supplies, pool safety, locked gun.
 Infant care (bathing, skin, clothing), emergency care plan, no aspirin use, family spacing, sibling & family relationships, sun screen.

Refer to appropriate agency.
 Next appointment 2 months or _____ Signature _____ Date _____