



Name: _____

Experience. Wellness. Everywhere.®

DOB: _____

Actual Age: _____

Language Spoken _____

Interpreter Name _____

Date: _____

5-6 MONTHS

NURSING INTAKE

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

INTERVAL HISTORY

Diet:	Breastfeed or Bottle Has WIC: Yes / No	Sleep position:	Meds/Vits:
Illnesses:		Physical activity:	
Accidents:		Exposure to tobacco smoke:	TB Risk: Yes / No

GROWTH-DEVELOPMENT:

<input type="checkbox"/> No head lag when pulled to sitting	<input type="checkbox"/> Rolls both ways
<input type="checkbox"/> Reaches for objects	<input type="checkbox"/> Sits briefly alone
<input type="checkbox"/> Bears weight on legs	<input type="checkbox"/> Gums, teets objects
<input type="checkbox"/> Orients to bell	<input type="checkbox"/> Babbles

PARENTAL CONCERNS:

PHYSICAL EXAMINATION

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

ASSESSMENT:

PLAN:

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

<input type="checkbox"/> DTaP	<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> Prevnar
<input type="checkbox"/> IPV	<input type="checkbox"/> Influenza vaccine (after 6 months)	<input type="checkbox"/> Immunization registry entry
<input type="checkbox"/> Hib	<input type="checkbox"/> WIC Referral	<input type="checkbox"/> Nutritional assessment
<input type="checkbox"/> Hep B	<input type="checkbox"/> PPD (if indicated)	<input type="checkbox"/> Rx for fluoride .25/.50 mg QD, refill till age 2
<input type="checkbox"/> Rotavirus		<input type="checkbox"/> Iron supplement (if indicated)

ANTICIPATORY GUIDANCE: Circle if discussed

Diet: Intro. Solids at 5 mos (rice cereal, vgs. & fruit), solids 1 new/week, start with iron-rich, no cow's milk yet, breast feeding, formula

Behavior: Begins to sit and crawl, discrimination of people. Education on Fluoride varnish treatment

Injury & Violence prevention: Smoke detector, poisoning risk, drug and toxic chemical storage, poison center phone number, lead poisoning prevention, gun lock.

Childproofing: Safety gates, window guards, pool fence, hot liquids and surfaces, hot water temp., choking prevention, sleeping position

Guidance: Consistent sleep schedule, teething and tooth care, blocks, repetitive games, no bottle recumbent, parent smoking, no aspirin use, sun screen, infant vs. toddler car seat, infant care (bathing, skin, clothing), childcare plan.

Refer to appropriate agency.

Next appointment [] 2 months or _____ Signature _____ Date _____