**SOUTHLAKE PEDIATRICS**
**HEALTH SUPERVISION VISIT 2 WEEKS**

Name: _____ DOB: _____
Date of Visit _____ Age _____
Parental Language Barrier: ☐ N ☐ Y _____

**PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS**
☐ No Concerns

_____
_____
_____

**PAST MEDICAL HISTORY**
Delivery: ☐ Vaginal ☐ C-section ☐ Breech
Hospital used for delivery: _____
Perinatal problems _____

_____

Hep B shot given? ☐ Yes ☐ No Date _____
Hearing Screen: ☐ Normal ☐ Abnormal
Medication: _____
Discharge diagnoses: _____

**PRESENT HISTORY**
Feeding: ☐ Breast ☐ Formula _____
Spitting/Gas _____
BM's per day _____
Wet diapers per day _____
Sleep hours/day _____
Sleep location for baby _____

**DEVELOPMENT**
Sees, Follows _____
Head Control _____

**SOCIAL/FAMILY**
Parents/Caregiver Smoker ☐ Yes ☐ No _____
Sibling/Household members & ages _____

_____
_____
Family medical history _____

_____
Parents'/Caregivers education/work _____

_____
Environmental (Support Systems, Sibling Rivalry, Financial Support, Family Planning, Gun in Home, etc.)

_____
_____

Information completed by: _____
Relationship to child: _____

**PHYSICAL EXAMINATION**
Length _____ % _____ Weight _____ % _____
HC _____ % _____ Temp _____ Pulse _____ RR _____

| N | AB | | COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Gen. Appearance | |
| ☐ | ☐ | Skin | |
| ☐ | ☐ | Head/Fontanel | |
| ☐ | ☐ | Eyes/RR | |
| ☐ | ☐ | Ears/Nose/Oropharynx | |
| ☐ | ☐ | Neck/Nodes | |
| ☐ | ☐ | Chest/Lungs | |
| ☐ | ☐ | Cardiovascular/Pulses | |
| ☐ | ☐ | Abdomen/Cord | |
| ☐ | ☐ | Genitalia | |
| ☐ | ☐ | Musculoskeletal/Hips | |
| ☐ | ☐ | Neuro/Reflexes /Tone | |

**ANTICIPATORY GUIDANCE**

**Diet – Type Recommended**
☐ Breastfeeding
☐ Maternal diet/Vitamins
☐ Vitamin D supplements
☐ No Solids

**Development**
☐ Stimulation/Music
☐ Comforting/Holding
☐ Rest for mother

**Injury Prevention**
☐ Need & Use of Car Seat
☐ Sibling Safety

☐ Bathing / Water temp
☐ Smoke Detectors
☐ Formula quantity/Mixing
☐ Fall prevention

**Medical Education**
☐ Sleep position - Back
☐ Signs of illness
☐ Temp taking
☐ No bottle propping
☐ Cord care
☐ Skin care
☐ Telephone calls
☐ Other _____

_____

**LABS:** ☐ Repeat neonatal screen ☐ Other _____

**IMMUNIZATIONS:** ☐ Hep B #1, if not done in hospital
☐ Vaccine Information Sheet given & discussed
Vaccine Concerns? ☐ No ☐ Yes: Resolved Deferred Refused
Comments _____
If vaccines refused, form signed? ☐ No ☐ Yes

**ASSESSMENT/RECOMMENDATIONS:**
☐ Healthy newborn _____

_____
_____
_____

☐ Return for 2 month checkup

_____, M.D.

SICK VISIT – Mod 25
CC:

HPI:

MDM:

>50% of _____ min visit spent counseling