

1 to 14 Day Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

| | | | |
|-------------|---------|----------------|---------------|
| NAME (Last) | (First) | ID | DATE OF BIRTH |
| DATE | AGE | ACCOMPANIED BY | RELATIONSHIP |

PRENATAL HISTORY

| | | | |
|---------------------------|---|-----------------|-------------------------|
| FIRST PRENATAL VISIT DATE | ALCOHOL, AMOUNT | TOBACCO, AMOUNT | STREET DRUGS |
| STDs (specify) | HEPATITIS B | HIV | OTHER MATERNAL PROBLEMS |
| WEEKS GESTATION | <input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN | BIRTH WEIGHT | WHERE DELIVERED |

PERINATAL HISTORY

| | | | |
|-------------------|---------------|-------|-------------------|
| DEFORMITIES/APGAR | ABNORMALITIES | OTHER | DATE OF D/C - LOS |
|-------------------|---------------|-------|-------------------|

INTERVAL HISTORY

| | |
|------------------------------|--|
| PAST MEDICAL HISTORY WNL | <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE) |
| DEVELOPMENTAL HISTORY WNL | <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE) |
| BEHAVIORAL HEALTH STATUS WNL | <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE) |

NUTRITIONAL ASSESSMENT

| | | | |
|---------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> BREAST | <input type="checkbox"/> FORMULA: | WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED | <input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON |
|---------------------------------|-----------------------------------|--|---|

PHYSICAL EXAM

| | | |
|--------|--------|--------------------|
| HEIGHT | WEIGHT | HEAD CIRCUMFERENCE |
|--------|--------|--------------------|

Are the following normal?

| | YES | NO | COMMENTS |
|-------------------------|-----|----|----------|
| Appearance | | | |
| Skin | | | |
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Mouth/Throat/Teeth/Gums | | | |
| Nodes | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen inc. cord | | | |
| Fem. Pulse | | | |
| Ext. Gen. | | | |
| Hip Abduc. | | | |
| Extremities | | | |
| Spine | | | |
| Neuro | | | |
| Other | | | |

LAB TESTS

| |
|--|
| |
|--|

SENSORY SCREEN

| | |
|--|---|
| NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED | NORMAL HEARING? (responds to noises, startles) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED |
|--|---|

DEVELOPMENT ASSESSMENT

| |
|---|
| IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, moro reflex) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED |

IMMUNIZATIONS

| |
|--|
| <input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST |
|--|

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

| |
|--|
| <input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> "BACK TO SLEEP" <input type="checkbox"/> OTHER |
|--|

| |
|-------------------|
| DIAGNOSIS: |
| PLAN: |
| SIGNATURE: |

