

# 4 to 6 Month 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

**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	<input type="checkbox"/> SOLIDS
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**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

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

**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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**SENSORY SCREEN**

NORMAL VISION? (red reflex, cover-uncover test, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., responds to sound, repeats sounds) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**DEVELOPMENT ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone-i.e., rolls over, reaches for objects, laughs, squeals)
<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
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE**

<input type="checkbox"/> CUP, FINGER FOODS	<input type="checkbox"/> NO BOTTLE IN BED	<input type="checkbox"/> TEETHING
<input type="checkbox"/> POOL & TUB SAFETY	<input type="checkbox"/> POISONS	<input type="checkbox"/> OTHER

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

