Pediatric & Adolescent Medicine

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PEDIATRIC HEALTH ASSESSMENT

2 TO 4 MONTHS

Today's Date: _____

Patient Name: _____DOB:_____Age_____

Accompanied by:_____Relationship:_____

Allergies:_____

Present concerns/complaints:_____

_____

DAILY LIVING: (Filled out by parent or guardian)
Breast Nursing every _____hours, for _____minutes
Formula Name:_____ ounces per bottle_____ No. bottles/day_____
Baby food (check if yes) Cereal_____ Fruit_____ Vegetables_____
Juices/water (ounces per day) _____
Vitamins/Fluoride.....____No____Yes
Any stressful situations in the household?.....____No____Yes
Anyone smoking in the household/care givers?.....____No____Yes
Is rear facing car seat used at all times?.....____No____Yes
Home have smoke alarms?.....No____Yes
Any reaction to previous immunizations?.....____No____Yes
Anyone at home on steroid medicine or has cancer?.....____No____Yes
Home built before 1956 or contain lead based paint?.....____No____Yes
Describe bowel habits (dirty diapers/day):_____
Describe personality:_____
Describe sleep position (side/back):_____
Describe work/day care situation:_____

DEVELOPMENT: (Filled out by parent or guardian)
Any concerns about vision or hearing?.....____No____Yes
Brings objects to mouth?.....____No____Yes
Follows moving objects with eyes?.....____No____Yes
Grasps or holds rattle?.....____No____Yes
Laughs out loud without being tickled or touched?.....____No____Yes
Lifts his/her head up while on his/her stomach?.....____No____Yes
Plays with his/her hands by touching them together?.....____No____Yes
Responds to sounds?.....____No____Yes

Doctor/Nurse Signature:_____