Pediatric & Adolescent Medicine

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PEDIATRIC HEALTH ASSESSMENT

5 to 7 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 or ounces if pumping_____

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:_____

Who lives in the home?_____

DEVELOPMENT: (Filled out by parent or guardian)

Acts different around strangers?.....____No____Yes

Any concerns about hearing or vision?.....____No____Yes

Grasps objects within reach?.....____No____Yes

Has good head control?.....____No____Yes

Makes babbling sounds?.....____No____Yes

Puts weight on legs?.....____No____Yes

Rolls over both ways?.....____No____Yes

Shakes a rattle?.....____No____Yes

Sits briefly with support?.....____No____Yes

Stops crying if he sees a bottle or parents?.....____No____Yes

Transfers toys from one hand to another hand?.....____No____Yes

Doctor/Nurse Signature:_____