



**Pediatric & Adolescent
Medicine**

Manish Dixit, M.D., F.A.A.P.

1902 S. US Hwy 59, Ste #5
Parsons, KS 67357
Ph: (620)421-0002
Fx: (888)820-2325

**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: _____