

Date \_\_\_\_\_ Time \_\_\_\_\_  
**Actual Age** \_\_\_\_\_ Weight \_\_\_\_\_ lb \_\_\_\_\_ oz. Height \_\_\_\_\_ in.  
 Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ Head Circ \_\_\_\_\_ Pain Score (0 – 5) \_\_\_\_\_  
☐ Environmental Screen ☐ Lead Risk Assessment ☐ Growth chart plotted  
 Nutrition: ☐ Breast ☐ Formula Type \_\_\_\_\_ ☐ Solids ☐ Vitamins ☐ Fluoride  
 Adverse Reactions (drug allergies): ☐ Yes\* \_\_\_\_\_ ☐ No \*If yes, also list on Patient Problem Summary in front of chart.  
☐ Parent section reviewed? ☐ Parent concerns addressed  
☐ Immunizations current (copy in chart) ☐ Off Schedule ☐ Parental refusal Explain \_\_\_\_\_  
 Problems: \_\_\_\_\_

**Current Medications:** ☐ None or list medications below.

Name	Dose	Frequency

Nurse's Signature

X

**Physical:** Check (☒) if normal. Circle if abnormal and describe.

☐ General Appearance

☐ Head/Face/Neck

☐ Eyes

☐ ENMT

☐ Respiratory

☐ Chest

☐ CV

☐ Abdomen

☐ Genitalia

☐ Skin

☐ Lymph nodes

☐ Extremities ☐ Hips

☐ Musculoskeletal

☐ Back

☐ Neuro

**Anticipatory Guidance:** ☐ Home Safety ☐ Car Safety ☐ Poisons ☐ Nutrition  
☐ Immunization Information ☐ Medication Education (if applicable)

**Assessment:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Plan:** ☐ Flu

☐ Hearing Subjective: Pass \_\_\_\_\_ Fail \_\_\_\_\_ ☐ Vision Subjective: Pass \_\_\_\_\_ Fail \_\_\_\_\_

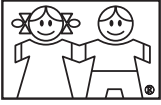
☐ Other \_\_\_\_\_

☐ Interpretive Conference Conducted Return \_\_\_\_\_

☐ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS** \_\_\_\_\_

☐ Parent/guardian verbalized understanding the **Plan of Care**. **INITIALS** \_\_\_\_\_

Physician/Practitioner's Signature X	Date / /	Time : AM/PM
-----------------------------------------	-------------	-----------------



Name

Date of Birth

Chart No.

## Parent Section 9 Month

### SECTION TO BE COMPLETED BY PARENT

#### Personal/Social History

*Does your child...*(check appropriate box for each question)

- |                                                     | Yes                      | No                       |
|-----------------------------------------------------|--------------------------|--------------------------|
| 1. Squeal, babble and imitate sounds?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Seem to hear well?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Move all extremities well?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Explore objects by shaking, banging or throwing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Try to pick up objects with thumb and finger?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Pull to a standing position?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ride in a rear-facing infant car seat?           | <input type="checkbox"/> | <input type="checkbox"/> |

*Are you **CONCERNED** about your child's...*

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| 8. Feedings?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Excessive spitting or vomiting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Bowel movements?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Congestion or wheezing?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Sleep habits?                  | <input type="checkbox"/> | <input type="checkbox"/> |

13. Is your child attending day care? ☐ ☐

#### Environmental Screening

*Does your child...*

- |                                                                                                                                      | Yes                      | No                       |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 14. Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)?                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have a sibling or playmate who now has or did have lead poisoning?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does anyone smoke in the household?                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have a swimming pool?                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |

#### History Update

- |                                                                     | Yes                      | No                       |
|---------------------------------------------------------------------|--------------------------|--------------------------|
| 19. Has there been a change in your child's medical history?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has there been a change in your child's family medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Change in household situation?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

#### Parent Comments (Please Print)

☐ Mother ☐ Father ☐ Other

22. Do you have any concerns you wish to discuss?

Yes No

☐ ☐

Signature

X

Date MM/DD/YY

/ /

Time 00:00 AM/PM

: