PEDIATRIC CONTINUITY CLINIC
AMBULATORY CARE CENTER
MEDICAL COLLEGE OF GEORGIA
AUGUSTA, GEORGIA

DATE:_______________

2 MONTH CHECK-UP

Name and number:__________________________________

Weight:___________ %:_______

Height:___________ %:_______

Head cir:__________ %:_______

Birth weight:____________ 1 month weight: _________

1 Month height:__________ 1 month head circumference:_________

Pertinent Medical Newborn and Interval History (Illnesses, medications, etc.):
____
____
____

Eating: If bottle, what formula; how much in 24 hrs:__________________________________
If breast, how long/feed; how many feeds /24 hrs:_______________________________
Encourage parents to not start solids or juice until at least 4 months of age

Sleeping: How long between feeds:____
Sleeps at least 5 hours at a time: Y______ N______

Development:
Smiles: Y______ N______
Turns to sound: Y______ N______
Sleeps on back only: Y______ N______
Watches you walk across the room: Y______ N______
Where does child sleep? ___________________________________

GENERAL PHYSICAL EXAMINATION - STAR IF YES AND DESCRIBE BELOW

Pain Scale________; Pain Score ________; Location: ________; MD Notified: _______; Initials: _______

	Normal Y N		Normal Y N
General Appearance	________	Ribs	________
Alertness	________	Heart	________
Hearing	________	Abdomen	________
Head Control	________	Genitalia	________
HEENT	________	Hips: thigh folds	________
Red Reflex	________	Ortolani	________
Neck	________	Barlows	________
Lungs	________	Neurological	________

OTHER PERTINENT PHYSICAL FINDINGS:
____
____
____
____

ANTICIPATORY GUIDANCE - 2 MONTH CHECK-UP:
ASK QUESTIONS AT LEAST ONCE BETWEEN 2 WEEKS AND 6 MONTHS OF AGE

	YES	NO
Smoking in the house	_____	_____
Is there a smoke alarm in the house	_____	_____
If guns in the home, are they locked in a cabinet	_____	_____
Lead Poisoning risk factors	_____	_____
Home built before 1960	_____	_____
Renovated within that time	_____	_____
Does a family member have increased exposure	_____	_____
Does a family member have an elevated lead level	_____	_____
Dud the child travel to the office in a car seat	_____	_____
Are electrical outlets covered	_____	_____
Medications, plants in house	_____	_____
Is the child in day care each day	_____	_____
Do you plan to use a walker	_____	_____

Remind parents always to be careful to **NOT:**

Leave the child on high places such as the changing table, bed or sofa
Put anything near the baby's reach that the baby might choke on such as food
Hold the baby while drinking or holding something hot
Leave out a recently used Curling Iron: a common cause of burns
Lay down the baby with the bottle

Encourage Parents to:

- Hold, cuddle, talk and sing to their baby
- Stimulate the child with age-appropriate toys
- Encourage partner/other caregiver to participate in the care of the child

DEVELOPMENTAL MILESTONES TO EXPECT BY 4 MOS OF AGE:

Rolls from stomach to back; smiles and laughs and vocalizes
Sleeps 10-11 continuous hours at night
May start to take cereal and solid foods

IMPRESSIONS: 1.____
2. ____

MEDICATIONS: 1.______________________ 2.______________________

IMMUNIZATIONS: 1.__________ 2.__________ **DTaP#1, HIB #1**
3.__________ 4.__________ **Hep #2 (1-4 month)**

RETURN TO CLINIC: 4 months of age **Polio #1 (IPV)**
Prevnar #1

Continuity Clinic Resident ______________________________________

Attending Note: ____

____

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Signature of Attending:_________________________