

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

DATE: _____

2 WEEK- 1 MONTH CHECK-UP

Weight: _____ : %: _____
Height: _____ : %: _____
Head cir. _____ : % _____
Newborn screen:
Normal: _____; Abn: _____

Name and number: _____
Birth weight: Kgm: _____ Pounds _____
Discharge weight: Kgm: _____ Pounds _____
Birth and neonatal history:
Normal: _____ : Abnormal: _____
If abn, please describe: _____

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: _____

Sleeping: How long at a time (expect 4 hours): _____
Sleeps at least 3-4 straight hrs at night: Y _____ N _____

Development: Smiles: Y _____ N _____
Responds to sound: Y _____ N _____
Sleeps on back only: Y _____ N _____
Where does child sleep: _____

GENERAL PHYSICAL EXAMINATION- STAR IF YES AND DESCRIBE BELOW:

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

DESCRIPTION OF PERTINENT PHYSICAL FINDINGS:

**ANTICIPATORY GUIDANCE - 2 WEEK - 1 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 on each level of the house	_____	_____
If guns are in the home, are they locked up in a cabinet	_____	_____
Lead Poisoning risk factors:		
home built before 1960	_____	_____
house renovated since that time period	_____	_____
does a family member have increased exposure	_____	_____
does a family member have an elevated lead level	_____	_____
Did the child travel to the hospital in a CAR SEAT	_____	_____
Is the child in Day Care each day	_____	_____
Do you plan to use a Walker	_____	_____
Are all Electric Outlets covered	_____	_____
Remind Parents always to be careful to NOT:		
Leave the child on high places such as the changing table, and 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		
Lie down the baby with the bottle; this can cause carious teeth and otitis		

DEVELOPMENTAL MILESTONES TO EXPECT BY 2 MOS OF AGE:

- Has eye contact and follows with eyes
- Smiles socially; makes vocalizing sounds
- Increased body tone with increased head control

IMPRESSIONS: 1. _____
2. _____

MEDICATIONS: 1. _____
2. _____

IMMUNIZATIONS: 1. _____ **Hep 1 (birth-2 months)**

Return to clinic: 2 months of age

Continuity Clinic Resident _____

Attending Note: _____

Signature of Attending: _____