

## 2 to 4 Month Child Health Check-Up Tracking Form

PLEASE PRINT

**PERSONAL**

Periodic    Interperiodic    Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

**INTERVAL HISTORY**

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

**NUTRITIONAL ASSESSMENT**

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON <input type="checkbox"/> SOLIDS
---------------------------------	-----------------------------------	--	---

**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

--

**SENSORY SCREEN**

NORMAL VISION? (red reflex, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., smiles and/or turns toward speech or sound, coos) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---	---

**DEVELOPMENT ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone – lifts chest, hands at midline, smiles spontaneously, rolls over one way, grasps rattle) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---

**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE**

<input type="checkbox"/> SOLID FOODS <input type="checkbox"/> CHOKING, ASPIRATION <input type="checkbox"/> FALLS <input type="checkbox"/> TEETHING <input type="checkbox"/> BABY-PROOF HOME <input type="checkbox"/> "BACK TO SLEEP"
---

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>