McLaren Medical Group

PEDIATRIC PHYSICAL EXAMINATION

AGE 1 Month

Date: _____ Age: _____ Accompanied By: _____

INTERVAL HISTORY / REVIEW OF SYSTEMS

Birth weight _____ Discharge weight _____
Prenatal History/Labor/Delivery Events: _____
_____
Concerns/Additional History: _____
_____
_____
_____
Nutrition: ☐ Breast ☐ Bottle
Formula _____ Amt/feeding _____ Frequency _____
Elimination: ☐ WNL _____
_____
Sleep: ☐ WNL _____
_____
Behavior: ☐ WNL _____
_____
Hearing: _____
Vision: _____

DEVELOPMENT

KEY:
☑ = Has achieved
☐ = Has not achieved

☐ Alert
☐ Fixes on face/object
☐ Raises head when prone
☐ Follows movement briefly

EDUCATION

Discussed and/or handout given:

☐ Nutrition
- ☐ Milk
  - ☐ Breast Feeding
  - ☐ Formula

☐ Elimination
☐ Fever (Signs/Symptoms)
☐ Sleep
- ☐ Back to Sleep

☐ Behavior/Development
- ☐ Social
- ☐ Communication Skills - Read to Baby
- ☐ Physical

☐ Injury Prevention
- ☐ Auto/Car Seat
- ☐ Falls
- ☐ No Strings Around Neck
- ☐ No Shaking
- ☐ Burns
  - ☐ Water Heaters
  - ☐ Smoke Detectors
  - ☐ Carbon Monoxide Detectors

☐ Passive Smoke Exposure
☐ Office Orientation (Contact Process)
☐ Other: _____
_____
_____
_____

PHYSICAL EXAMINATION

Weight _____ Height _____ Head Circumference _____
See Growth Chart
T: _____ P: _____ R: _____

KEY: ☑ WNL
☐ Not addressed or exceptions/abnormalities must be documented

☐ Gen. Appearance _____
☐ Head/Fontanel _____
☐ Eye/Red Reflex _____
☐ Ears _____
☐ Nose _____
☐ Mouth/Throat _____
☐ Lungs _____
☐ Heart _____
☐ Femoral Pulses _____
☐ Abdomen _____
☐ Genitalia _____
- ☐ Male/Testes Down _____
- ☐ Female _____

☐ Extremities _____
☐ Back _____
☐ Skin _____
☐ Neurologic _____
Comments: _____
_____
_____

ASSESSMENT

☐ Well child
_____
_____
_____
_____
_____

PLANS/FOLLOW-UP

_____
_____
_____
_____
_____
☐ Next well child at age 2 months

IMMUNIZATIONS

☐ Hep B #2
☐ MCIR Updated
☐ Physician provided face-to-face counseling with the parent/guardian at the time of administration of (list number) _____ vaccine(s) at this visit.

SCREENINGS

☐ Newborn screening (if not previously received)

☐ Parent/guardian verbalized understanding of education/instructions
☐ See Progress Notes for additional documentation

Clinical Staff Signature: _____

Provider Signature: _____

Patient Name:

Date of Birth:

PEDIATRIC PHYSICAL EXAMINATION (1 Month)

MM-34301-B (10/07)