McLaren Medical Group
PEDIATRIC PHYSICAL EXAMINATION
AGE 2 Months

Date: ______________________________ Age: ________________ Accompanied By: ____

INTERVAL HISTORY / REVIEW OF SYSTEMS

See Pediatric/Adolescent History Form/Problem List/Med. List

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

- ☐ Lifts Head When Prone
- ☐ Coos
- ☐ Grasps Objects
- ☐ Follows Objects with Eye Past Midline
- ☐ Smiles Responsively

EDUCATION

Discussed and/or handout given:

- ☐ Nutrition
  - ☐ Breast Feeding
  - ☐ Formula
  - ☐ Solid Foods
    - ☐ No Honey
    - ☐ Wait Until 4-6 Months
- ☐ Elimination
- ☐ Fever (Signs/Symptoms)
- ☐ Sleep
  - ☐ Back to Sleep
- ☐ Behavior/Development
  - ☐ Social
  - ☐ Communication Skills - Read to Baby
  - ☐ Physical
- ☐ Injury Prevention
  - ☐ Auto/Car Seat
  - ☐ Burns
    - ☐ Water Heaters
    - ☐ Smoke Detectors
  - ☐ Falls
  - ☐ Sun
- ☐ Passive Smoke Exposure
- ☐ 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 4 months

IMMUNIZATIONS

☐ DTaP #1 ☐ IPV #1 ☐ Prevnar #1 ☐ Hib #1
☐ Hep B #2 ☐ Rotavirus #1 ☐ 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.

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

Clinical Staff Signature: ______________________________

Provider Signature: ______________________________

Patient Name:

Date of Birth: