McLaren Medical Group
PEDIATRIC PHYSICAL EXAMINATION
AGE 4 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

☐ Holds head erect
☐ Blows bubbles
☐ Rolls front to back
☐ Coos
☐ Follows 180°
☐ Reaches/grabs objects
☐ Laughs/squeals
☐ Bears weight on legs

EDUCATION

Discussed and/or handout given:

- ☐ Nutrition
  - ☐ Breast Feeding
  - ☐ Formula
  - ☐ Solid Foods
    - ☐ When and How to Add
    - ☐ No Honey
- ☐ Elimination
- ☐ Fever (Signs/Symptoms)
- ☐ Sleep
- ☐ Behavior/Development
  - ☐ Social
  - ☐ Communication Skills - Read to Baby
  - ☐ Physical
- ☐ Injury Prevention
  - ☐ Auto/Car Seat
  - ☐ Burns
    - ☐ Water Heaters
    - ☐ Smoke Detectors
    - ☐ Carbon Monoxide Detectors
  - ☐ Falls
  - ☐ Sun
  - ☐ Walkers - Dangers
- ☐ 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 ______________________________
☐ Eyes ______________________________
☐ 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 6 months

IMMUNIZATIONS

☐ DTaP #2 ☐ IPV #2 ☐ Prevnar #2
☐ Hib #2 ☐ Rotavirus #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.

☐ 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 (4 Months)

MM-34301-D (10/07)