



# EARLY HEAD START WELL BABY CHECKUP 4 MONTHS



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ PID#: \_\_\_\_\_

## EXAMS COMPLETED DURING THE VISIT

- Hearing, Clinical Observation
- Vision, Clinical Observation
- TB Risk Assessment
  - Risk Factors not present; TB Skin Test not required
- TB Risk Factors present
  - TB Skin Test performed (unless previous positive Skin Test documented)
  - TB Test Date: \_\_\_\_\_ Date Read: \_\_\_\_\_
    - Communicable TB disease not present
- Oral Visual Exam
- Height: \_\_\_\_\_ in.
- Weight: \_\_\_\_\_ lb.
- Head Circumference \_\_\_\_\_
- Anemia Risk Assessment
  1. Do you ever struggle to put food on the table?
    - No  **Yes - If Yes, Hgb/Hct test is required**
  2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
    - Yes  **No - If No, Hgb/Hct test is required**
  - Anemia Risk Factors present
  - Hgb/Hct Test Results: \_\_\_\_\_
  - \*Date: \_\_\_/\_\_\_/\_\_\_ \*(If different from exam date)

## DEVELOPMENTAL MILESTONES

- Coos, laughs aloud
- Brings hands together, toys to mouth
- Follows 180 degrees
- Sits with head steady when held
- Rolls over one way

## NUTRITION ASSESSMENT

Breast Milk:  Yes  No Formula:  Yes  No  
 Ounces/feeding: \_\_\_\_\_  
 Feedings/24 hrs: \_\_\_\_\_  
 Juice:  No  Yes: \_\_\_\_\_  
 Regular bowel movements:  
 Yes  No: \_\_\_\_\_  
 Feeding issues:  No  Yes: \_\_\_\_\_  
 Solid foods:  No  Yes: \_\_\_\_\_

## ANTICIPATORY GUIDANCE

- Car seat safety
- Choking hazards– appropriate foods
- Small objects out of reach
- Burns – hot liquids
- Second hand smoke

## IMMUNIZATIONS RECEIVED

(circle which dose was administered)

- Polio 1 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- DTP 1 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- Hib 1 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- Hep B 1 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- Other: \_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## COMMENTS/CONCERNS:

6 MONTH APPOINTMENT SCHEDULED:

Print Name of Doctor \_\_\_\_\_ Signature/ Official Stamped Signature \_\_\_\_\_ Exam Date \_\_\_/\_\_\_/\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**EHS Staff Only**  
**Date Received:**  
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