EARLY HEAD START WELL BABY CHECKUP
1 MONTH

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 _____

DEVELOPMENTAL MILESTONES

- ❑ Shows better head control
- ❑ Lifts his/her head when lying on tummy
- ❑ Grasps your finger
- ❑ Stares at faces briefly
- ❑ Becomes quiet when others speak
- ❑ Different cries to indicate need
- ❑ Calms when swaddled and rocked

NUTRITION ASSESSMENT

Breast Milk: □ Yes □ No Formula: □ Yes □ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Regular bowel movements: □ Yes □ No: _____

Feeding issues: □ No □ Yes: _____

IMMUNIZATIONS RECEIVED

- ❑ Polio 1 _____/_____/_____
- ❑ DTP 1 _____/_____/_____
- ❑ Hib 1 _____/_____/_____
- ❑ Hep B 1 _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Burns, hot water temp 120° f
- ❑ Smoke detectors
- ❑ Immunizations risks
- ❑ Falls
- ❑ Second hand smoke

COMMENTS/CONCERNS:

2 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____