PEDIATRIC HEALTH
ASSESSMENT HEALTH
2 Week

CHILD'S NAME: _____DATE: _____ AGE: _____

PRESENT CONCERNS/PROBLEMS: _____

_____

_____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

SOCIAL/FAMILY HISTORY

Who lives at home? _____

Adjustment to new child. Any problems?_____

Reaction of siblings to new child_____

Work Plans for Mom _____

Child care plans_____

NUTRITION

Feeding: circle Bottle or Breast

Formula Type _____ Breast fed: How often - every _____ hours / number feeds _____ per day

Ounces per Feed_____ Total minutes of breast feeding per feed_____

Hours between feed_____ Feedings/24 hours_____

Is baby taking any vitamins? ☐ Yes ☐ No If so what type? _____

URINE: Number of wet diapers per day _____

STOOL: Number of bowel movements per day _____

Does baby sleep in own bassinette? ☐ Yes ☐ No Sleep Position: _____

Behavior: _____

Toxic exposure: Lead ☐ Yes ☐ No Smokers in household ☐ Yes ☐ No Exposure to TB: ☐ Yes ☐ No

Smoke Detector in house at home? ☐ Yes ☐ No Car seat always used? ☐ Yes ☐ No

DEVELOPMENT

Motor
- □ Raises head slightly in prone position

Sensory
- □ Blinks in reaction to bright light
- □ Follows object to midline
- □ Responds to sound