

**WBC Opportunities**  
**Early Head Start**  
**Well Child Exam**  
**0 to 5 Months**

Name \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Age of child \_\_\_\_\_

<b>HEAD START HEALTH REQUIREMENTS</b>	<b>NUTRITIONAL ASSESSMENT/EDUCATION</b>
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This child is required to have a complete physical examination, including height/weight, head circumference and vision/hearing screening. These items are required based on Texas Health Steps Medical Checkups Periodicity Schedule. Please complete this form, sign, date and send with the parent.

<b>HISTORY/PARENTAL CONCERNS</b>	<b>Y N COMMENTS (If concerns, explain below)</b>
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<input type="checkbox"/>	<input type="checkbox"/>	WIC
<input type="checkbox"/>	<input type="checkbox"/>	Formula (type _____) Amt. _____ oz. q _____ hr.
<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding (frequency q _____ hr.)
<input type="checkbox"/>	<input type="checkbox"/>	Solids: _____
<input type="checkbox"/>	<input type="checkbox"/>	Feeding Problems
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems

<b>ALLERGIES</b>	<input type="checkbox"/> NKDA <input type="checkbox"/> Allergies:
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<b>MEDICATIONS</b>	<input type="checkbox"/> No regular meds <input type="checkbox"/> Current meds:
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<b>SCREENING</b>	
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Gross Hearing	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Gross Vision	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
PDQ or complete Denver	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail <input type="checkbox"/> NA
Dental Screening	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer

<b>Y</b>	<b>N</b>	<b>MENTAL HEALTH SCREENING</b>
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<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying/colic
<input type="checkbox"/>	<input type="checkbox"/>	Family stresses
<input type="checkbox"/>	<input type="checkbox"/>	Day care (If yes, where? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Other (see comments)
<input type="checkbox"/>	<input type="checkbox"/>	Good self esteem
<input type="checkbox"/>	<input type="checkbox"/>	Normal sleeping

Explain Comments
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<b>PHYSICAL EXAM</b>	(Plot Ht., wt, HC on growth curve)
Ht. _____ in _____ %	Temp _____
Wt. _____ lb _____ %	Pulse _____
HC _____ cm _____ %	Resp. _____

<b>N</b>	<b>A</b>	<b>NE</b>	<b>COMMENTS</b>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>General</b> (nl appearance / behavior)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin</b> (no birthmarks)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Head</b> (fontanelle / face / symmetry / sutures)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes</b> (Red reflex/Corneal light reflexes nl fixes and follows)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Oral Health</b> teeth/gums nl
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Nose/pharynx</b> (clear)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neck</b> (no masses, full ROM)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lungs</b> (BS = and clear)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>CV</b> (RRR, No murmur, nl S1, S2) Femoral pulses present
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Abdomen</b> (no HSM, no masses, good BS)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitalia (F):</b> nl anatomy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(M)</b> testes ↓ ↓ <input type="checkbox"/> L <input type="checkbox"/> R, No hypospadias
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anus</b> (nl position)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Extremities</b> (symmetrical mvt, full ROM)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Spine/Hips</b> (stable, no hip clunk)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurologic</b> Muscle tone nl bilat. _____ over
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DTRs 2+ bilat. (biceps, patellar, Achilles)

Explain significant/Abnormal PE findings
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Name \_\_\_\_\_  
 DOB \_\_\_\_\_

DEVELOPMENTAL ASSESSMENT (if no explain below)		
0-1 Month	2-3 Months	4-5 Months
Y N <input type="checkbox"/> <input type="checkbox"/> Regards face <input type="checkbox"/> <input type="checkbox"/> Startles to loud noise <input type="checkbox"/> <input type="checkbox"/> Equal movement of arms and legs <input type="checkbox"/> <input type="checkbox"/> Lifts head	Y N <input type="checkbox"/> <input type="checkbox"/> Smiles responsively <input type="checkbox"/> <input type="checkbox"/> Inspects surroundings <input type="checkbox"/> <input type="checkbox"/> Vocalizes in play <input type="checkbox"/> <input type="checkbox"/> Lifts head when prone <input type="checkbox"/> <input type="checkbox"/> Startles to loud noise	Y N <input type="checkbox"/> <input type="checkbox"/> Rolls front to back <input type="checkbox"/> <input type="checkbox"/> Hands together <input type="checkbox"/> <input type="checkbox"/> Laughs, squeals, coos <input type="checkbox"/> <input type="checkbox"/> Head steady in a supported position <input type="checkbox"/> <input type="checkbox"/> Head turns toward your voice

HEALTH EDUCATION (* = Must Discuss)				
	Behavior	Injury Prevention	Health Promotion	Nutrition
<b>0-1 Mo.</b>	<input type="checkbox"/> Excessive crying/colic <input type="checkbox"/> Infant temperament <input type="checkbox"/> Taking time for yourself* <input type="checkbox"/> Bonding with baby*	<input type="checkbox"/> Car seat faces rear* <input type="checkbox"/> Sleep position* <input type="checkbox"/> Microwave precautions <input type="checkbox"/> Crib safety <input type="checkbox"/> Water temperature	<input type="checkbox"/> Care of skin/cord/circ. <input type="checkbox"/> Thermometer use – OTC meds, bulb suctioning* <input type="checkbox"/> When to call clinic* <input type="checkbox"/> Family Planning*	<input type="checkbox"/> No solids until 4 mo. – 6 mo.* <input type="checkbox"/> Formula preparation <input type="checkbox"/> Infant held for bottle <input type="checkbox"/> Breast feeding, education and support*
<b>2-5 Mo.</b>	<input type="checkbox"/> Excessive crying/colic <input type="checkbox"/> Infant temperament <input type="checkbox"/> Taking time for yourself* <input type="checkbox"/> Bonding with baby*	<input type="checkbox"/> Car seat faces rear* <input type="checkbox"/> Choking management <input type="checkbox"/> Sleep position* <input type="checkbox"/> Discourage walker <input type="checkbox"/> Water temperature <input type="checkbox"/> Falls	<input type="checkbox"/> Immunizations <input type="checkbox"/> Thermometer use, OTC meds, bulb suctioning* <input type="checkbox"/> Smoking at home* <input type="checkbox"/> Prone play <input type="checkbox"/> Family Planning*	<input type="checkbox"/> Introduction of solids at 4-6 mos.* <input type="checkbox"/> Formula preparation <input type="checkbox"/> Infant held for bottle* <input type="checkbox"/> Breast feeding support*

**Assessment:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Plan:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NBS**  Done today     Done in the past with results pending     Results on chart  
 HIB 1\_\_2     IPV 1\_\_2     DTaP 1\_\_2     Hep B 1\_\_2     Prevnar 1\_\_2  
 Rotovirus 1\_\_2

**Other:**  
 \_\_\_\_\_

**Next appointment:**  
 \_\_\_\_\_

**Date:** \_\_\_\_\_ **Nurse Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Provider Signature:** \_\_\_\_\_