

# 1 to 14 Day Child Health Check-Up Tracking Form

PLEASE PRINT

**PERSONAL**

Periodic    Interperiodic    Parent/Caregiver Request

NAME	<small>(Last)</small>	<small>(First)</small>	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY		RELATIONSHIP

**PRENATAL HISTORY**

FIRST PRENATAL VISIT DATE	ALCOHOL, AMOUNT	TOBACCO, AMOUNT	STREET DRUGS
STDs (specify)	HEPATITIS B	HIV	OTHER MATERNAL PROBLEMS
WEEKS GESTATION	<input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN	BIRTH WEIGHT	WHERE DELIVERED

**PERINATAL HISTORY**

DEFORMITIES/APGAR	ABNORMALITIES	OTHER	DATE OF D/C - LOS
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**INTERVAL HISTORY**

PAST MEDICAL HISTORY WNL    YES    NO (IF NO, DESCRIBE)  
 DEVELOPMENTAL HISTORY WNL    YES    NO (IF NO, DESCRIBE)  
 BEHAVIORAL HEALTH STATUS WNL    YES    NO (IF NO, DESCRIBE)

**NUTRITIONAL ASSESSMENT**

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	VITAMINS <input type="checkbox"/> IRON <input type="checkbox"/>
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**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen inc. cord			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

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**SENSORY SCREEN**

NORMAL VISION? <small>(red reflex)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? <small>(responds to noises, startles)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**DEVELOPMENT ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, Moro reflex)  
 YES    NO    REFERRED

**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE**

<input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> "BACK TO SLEEP" <input type="checkbox"/> OTHER
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<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>