CLEAR FORM

Well Child | 2 Month Visit

Accompanied By:	Preferred Language:	Date/Time:	**Name:**

Weight (%):	Length (%):	Weight-for-length (%):	HC (%):	ID Number:

Vitals (*if indicated*): Temp:	HR:	Resp Rate:	SpO_2:	Birth Date:	Age:	Sex: M ○ F ○

HISTORY

Concerns and Questions: ☐ None

Interval History: ☐ None

Medical History: ☐ Infant has special health care needs.

Areas reviewed and updated as needed

☐ Past Medical History (See Initial History Questionnaire.)

☐ Surgical History (See Initial History Questionnaire.)

☐ Problem List (See Problem List.)

Medications: ☐ None

☐ Reviewed and updated (See Medication Record.)

Allergies: ☐ No known drug allergies

Screening Results:

Newborn blood screening: ☐ Normal

☐ Abnormal

Newborn hearing screening: ☐ Passed BL ☐ Referred _____

Nutrition:

☐ Breast milk:

Minutes per feeding: _____ Hours between feedings: _____

Feedings per 24 hours: _____

Problems with breastfeeding:

Vitamin D supplements: _____ ☐ None

☐ Formula: Type/brand: _____ Source of water: _____

Feedings per 24 hours: _____ Ounces per feeding: _____

Problems with bottle-feeding: _____

Elimination: ☐ Regular soft stools ☐ Normal urine stream

Sleep: ☐ Normal pattern ☐ On back ☐ Safe sleep surface

Behavior: ☐ No concerns

Activity (tummy time):

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP
- Smiles responsively (ie, social smile)

☐ VERBAL LANGUAGE
- Vocalizes with simple cooing

☐ GROSS MOTOR
- Lifts head and chest in prone

☐ FINE MOTOR
- Opens and shuts hands

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SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): ☐ Social History ☐ Family History

Changes since last visit: _____

Smoking household: ☐ No ☐ Yes: _____

Parental support and work-family balance: _____

Observation of parent-infant interaction: _____

Parents working outside home: ☐ One parent ☐ Both parents Child care: ☐ Parent(s) ☐ Family ☐ In-home ☐ Center ☐ Other: _____

REVIEW OF SYSTEMS

☐ A 10-point review of systems was performed and results were negative except for any positive results listed below.
Bold = Focus area for this Bright Futures Visit

Constitutional: _____ **Respiratory:** _____ **Skin:** _____

Eyes: _____ **Gastrointestinal:** _____ Neurological: _____

Head, Ears, Nose, and Throat: _____ **Genitourinary:** _____ Other: _____

Cardiovascular: _____ Musculoskeletal: _____ Other: _____

PHYSICAL EXAMINATION

☑ = System examined **Bold** = Focus area for this Bright Futures Visit
Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

☐ **General:** Alert, active infant. **Normal interval growth in height, weight, and head circumference. Normal weight-for-length for age.**

_____

☐ **Head:** Normocephalic and atraumatic. **No positional skull deformities. Anterior fontanelle open and flat.** _____

☐ **Eyes: Fixes and follows. Red reflex present bilaterally. No opacification.** Normal funduscopic examination findings. _____

☐ Ears, nose, and throat: Tympanic membranes with visible light reflex bilaterally. No oral lesions or thrush.

☐ Neck: Supple, with full range of motion **without torticollis.** _____

☐ **Heart:** Regular rate and rhythm. **No murmur. Symmetrical femoral pulses.** _____

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing. _____

☐ Abdomen: Soft, with no palpable masses. _____

☐ Genitourinary:

- ☐ Normal female external genitalia. _____
- ☐ Normal male external genitalia, with testes palpable in scrotum bilaterally. _____

☐ **Musculoskeletal:** Spine straight. **Negative Ortolani and Barlow maneuvers.** _____

☐ **Neurological: Moves all extremities symmetrically. Normal strength and tone.** _____

☐ **Skin:** Warm and well perfused. **No lesions, birthmarks, or bruising.** _____

Other comments: _____

ASSESSMENT

☐ Well child ☐ Normal interval growth (See growth chart.) ☐ Age-appropriate development

Well Child | 2 Month Visit

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **SOCIAL DETERMINANTS OF HEALTH**
- Living situation and food security
- Family support
- Child care

☐ **NUTRITION AND FEEDING**
- General guidance on feeding and delaying solid foods
- Hunger and satiety cues
- Breastfeeding or formula-feeding guidance

☐ **PARENT AND FAMILY HEALTH**
- Postpartum checkup
- Maternal depression
- Sibling relationships

☐ **INFANT BEHAVIOR AND DEVELOPMENT**
- Parent-infant relationship
- Parent-infant communications
- Sleeping
- Media
- Playtime
- Fussiness

☐ **SAFETY**
- Car safety seats
- Safe sleep
- Safe home environment: burns, drowning, and falls

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed Administered today: _____ ☐ Up-to-date for age

Universal Screening:

☐ Maternal depression: Screening tool used: _____ Result: ☐ Neg ☐ Pos: _____

Newborn blood screening: Result: ☐ Normal ☐ Needs follow-up: _____

Newborn hearing screening: Result: ☐ Passed BL ☐ Referred right/left/BL ☐ Needs follow-up: _____

Selective Screening (based on risk assessment) (See Previsit Questionnaire.):

☐ BP ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 4 months ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition