**General**

- **Skin:**
- **Fontanels:**
- **Eyes:** Red Reflex
- **Appearance:**
- **Ears, TMs:**
- **Nose:**
- **Lips/Palate:**
- **Teeth/Gums:**
- **Tongue/Pharynx:**
- **Neck/Nodes:**
- **Chest/Breast:**
- **Lungs:**
- **Heart:**
- **Abd/Umbilicus:**
- **Genitalia/Femoral Pulses:**
- **Extremities, Clavicles, Hips:**
- **Muscular:**
- **Neuromotor:**
- **Back/Sacral dimple:**

**Motor skills** (observe head, trunk and limb control)

- Visually tracks objects to midline: **Y** **N**
- Moves arms and legs equally: **Y** **N**
- Arms and legs are usually flexed: **Y** **N**
- Full head lag in pull to sit from supine: **Y** **N**
- Raises head slightly off table in prone: **Y** **N**
- Moro, root, grasp, suck present: **Y** **N**
- Face symmetric with cry: **Y** **N**

**Fine Motor skills**

- Hands are usually fisted: **Y** **N**
- Grasps objects reflexively: **Y** **N**

**Language/Socioemotional skills**

- Vocalizes/Coo's: **Y** **N**
- Startles at loud noise: **Y** **N**

**Parent – Infant Interaction** (maternal depression present in 50% of post-partum mothers):

- Interaction appears age appropriate: **Y** **N**

**Muscular & Neuromotor**

- **Back/Sacral dimple:**

**Sensory Screening:**

- Any parent concerns about vision or hearing? **☐ Yes** **☐ No**
  - **Vision:**
    - Blinks in reaction to bright light: **☐ Yes** **☐ No**
  - **Hearing:**
    - Passed NBHS (B): **☐ Yes** **☐ Not Given** **☐ U/K** **☐ Failed NBHS**
    - Responds to sounds: **☐ Yes** **☐ No** **☐ Left** **☐ Right**

**Physical Examination (check box):**

- **Comments:**
  - General
  - Skin
  - Fontanels
  - Eyes: Red Reflex, Appearance
  - Ears, TMs
  - Nose
  - Lips/Palate
  - Teeth/Gums
  - Tongue/Pharynx
  - Neck/Nodes
  - Chest/Breast
  - Lungs
  - Heart
  - Abd/Umbilicus
  - Genitalia/Femoral Pulses
  - Extremities, Clavicles, Hips
  - Muscular
  - Neuromotor
  - Back/Sacral dimple

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**Clinician Observations/History:**

- **Motor skills** (observe head, trunk and limb control)
- **Fine Motor skills**
- **Language/Socioemotional skills**
- **Parent – Infant Interaction** (maternal depression present in 50% of post-partum mothers):
- Interaction appears age appropriate

**Clinician concerns re interaction:**

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**OHCA Revised 03/13/2014**
### ANTICIPATORY GUIDANCE:
Select at least one topic in each category (as appropriate to family):

**Injury/Serious Illness Prevention:**
- Car Seat
- Falls
- No strings around neck
- No shaking
- Burns-hot water heater max temp 125 degrees F
- Smoke alarms
- No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
- No sun exposure
- Fever management
- Other: _____________________________________________

**Violence Prevention:**
- Adequate support system?
- Adequate respite?
- Feel safe in neighborhood?
- Domestic Violence?
- No Shaking
- Other: _____________________________________________

**Sleep Positioning Counseling:**
- Sleep (on back)
- Sleep Safety
- Normal for newborns to sleep most of the day and night
- Other: _____________________________________________

**Nutrition Counseling:**
- Breast
- Formula
- Solids (4-6mo)
- 3-4 hour between feeding
- Less frequent stools typical for bottle fed infants
- 5-8 wet diapers/day
- Vitamins/Fluoride
- No honey
- No bottle prop
- No microwave
- Other: _____________________________________________

**What to anticipate before next visit:**
- More awake time
- Sleep cycle gets more regular
- Change in feeding/stooling patterns
- Other: _____________________________________________

### PROCEDURES:
- Hereditary/Metabolic Screening needed
- Hereditary/Metabolic Screening results reviewed – Normal
- Hereditary/Metabolic Screening results reviewed – Other:

### IMMUNIZATIONS DUE at this visit:
- HepB #
- Given
- Not Given
- Up to Date

**Reason Not Given if due:** List Vaccine(s) not given:
- Vaccine not available
- Child ill
- Parent Declined
- Other

**Assessment:**
- Healthy, no problems

**Plan/Recommendations:**
- Do vaccines/procedures marked above
- Anticipatory guidance discussed (as described in box above)

**Next Health Supervision (EPSDT) Visit Due:**

Provider Signature: __________________________ Date: __________________________