

Naval Hospital Oak Harbor Prime Health Center
Four Month Well Child Visit

Date:

Time:

Provider Note

Interval History:

Past Medical History:

Medications:

Allergies:

Immunizations:

Family/Social History Update:

Development: Shakes rattle Laughs out loud Rolls over from front to back
 Regards object Turns to voice Raises body on hands in prone position

Physical Exam

Weight: _____ kg _____ lb _____ %ile
Length: _____ cm _____ in _____ %ile
OFC: _____ cm _____ in _____ %ile

Vital Signs N/A

Pain: _____ (0-10)

Temp: _____ HR: _____
RR: _____ O2 Sat: _____

<u>Nl</u>	<u>Abn</u>	
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance:
<input type="checkbox"/>	<input type="checkbox"/>	Head:
<input type="checkbox"/>	<input type="checkbox"/>	Eyes:
<input type="checkbox"/>	<input type="checkbox"/>	ENT:
<input type="checkbox"/>	<input type="checkbox"/>	Neck:
<input type="checkbox"/>	<input type="checkbox"/>	Chest:
<input type="checkbox"/>	<input type="checkbox"/>	Heart:
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen:
<input type="checkbox"/>	<input type="checkbox"/>	Genitals:
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal:
<input type="checkbox"/>	<input type="checkbox"/>	Skin:
<input type="checkbox"/>	<input type="checkbox"/>	Neuro:

Assessment

Plan

Anticipatory Guidance

Immunizations: DTaP, IPV, Hib-HepB, Prevnar

Other:

Follow-up: 6 months of age other: _____

Addressograph

Examiner's Signature/Name Stamp

