

**D  
A  
T  
A**

**B  
A  
S  
E**

**M  
A  
N  
A  
G  
E  
M  
E  
N  
T**

DATE:	1 MONTH	DATE:	2 MONTHS	DATE:	3 MONTHS
AGE: _____	WEIGHT: _____	TEMP.: _____	AGE: _____	WEIGHT: _____	TEMP.: _____
LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____
<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>	
<u>DIET</u>		<u>DIET</u>		<u>DIET</u>	
<u>DEVELOPMENT</u>		<u>DEVELOPMENT</u>		<u>DEVELOPMENT</u>	
1. Prone - lifts head _____		1. Prone - lifts head 45 ° _____		1. Prone - lifts head 90 ° _____	
2. Regards face _____		2. Vocalizes _____		2. Laughs _____	
3. Follows to midline _____		3. Smiles responsively _____		3. Has eye contact _____	
4. Responds to noise _____				4. Moves all extremities easily _____	
<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities	
Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>
Head	<input type="checkbox"/>	Head	<input type="checkbox"/>	Head	<input type="checkbox"/>
Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>
ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>
Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>
Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>
Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>
Back	<input type="checkbox"/>	Back	<input type="checkbox"/>	Back	<input type="checkbox"/>
Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>
Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>
<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>	
<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>	
<u>TEACHING</u>		<u>TEACHING</u>		<u>TEACHING</u>	
1. Feeding - Vitamins, Iron		1. Feeding		1. Feeding	
2. Sneezing, hiccoughs, straining, etc.		2. Immunizations		2. Sleeping (accomplished independently)	
3. Holding/Affection		3. Medications - use and abuse		3. Accidents	
4. Skin care		4. Stimulation			
5. Bottle propping		5. Diaper rash/skin care			
6. WIC Supplemental Feeding Program		6. Sleeping schedule			
Appointment to next Clinic _____		Appointment to next Clinic _____		Appointment to next Clinic _____	
Signature: _____		Signature: _____		Signature: _____	

ADDRESSOGRAPH

**WELL BABY CLINIC  
1-3 MONTHS**

IHS-5-2 (FRONT)  
(1/89)

**D  
A  
T  
A**

**B  
A  
S  
E**

**M  
A  
N  
A  
G  
E  
M  
E  
N  
T**

DATE:	4 MONTHS	DATE:	6 MONTHS	DATE:	8 MONTHS
AGE: _____ WEIGHT: _____ TEMP.: _____		AGE: _____ WEIGHT: _____ TEMP.: _____		AGE: _____ WEIGHT: _____ TEMP.: _____	
LENGTH: _____ HEAD: _____		LENGTH: _____ HEAD: _____		LENGTH: _____ HEAD: _____	
<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>	
<u>DIET</u>		<u>DIET</u>		<u>DIET</u>	
<u>DEVELOPMENT</u> 1. Head Steady - sitting _____ 2. Eyes follow 180 ° _____ 3. Grasps rattle _____ 4. Squeals _____		<u>DEVELOPMENT</u> 1. No head lag with pulled to sitting position _____ 2. Reaches for objects (5 mos.) _____ 3. Rolls both ways _____ 4. Supine, turns head full 180 ° _____		<u>DEVELOPMENT</u> 1. Sits without support _____ 2. Feeds self cracker _____ 3. Transfers object from one hand to another _____ 4. Focuses on small objects _____	
<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities	
Gen.App. <input type="checkbox"/>	<input type="checkbox"/>	Gen.App. <input type="checkbox"/>	<input type="checkbox"/>	Gen.App. <input type="checkbox"/>	<input type="checkbox"/>
Skin <input type="checkbox"/>	<input type="checkbox"/>	Skin <input type="checkbox"/>	<input type="checkbox"/>	Skin <input type="checkbox"/>	<input type="checkbox"/>
Head <input type="checkbox"/>	<input type="checkbox"/>	Head <input type="checkbox"/>	<input type="checkbox"/>	Head <input type="checkbox"/>	<input type="checkbox"/>
Nodes <input type="checkbox"/>	<input type="checkbox"/>	Nodes <input type="checkbox"/>	<input type="checkbox"/>	Nodes <input type="checkbox"/>	<input type="checkbox"/>
ENT <input type="checkbox"/>	<input type="checkbox"/>	ENT <input type="checkbox"/>	<input type="checkbox"/>	ENT <input type="checkbox"/>	<input type="checkbox"/>
Chest <input type="checkbox"/>	<input type="checkbox"/>	Chest <input type="checkbox"/>	<input type="checkbox"/>	Chest <input type="checkbox"/>	<input type="checkbox"/>
Lungs <input type="checkbox"/>	<input type="checkbox"/>	Lungs <input type="checkbox"/>	<input type="checkbox"/>	Lungs <input type="checkbox"/>	<input type="checkbox"/>
Heart <input type="checkbox"/>	<input type="checkbox"/>	Heart <input type="checkbox"/>	<input type="checkbox"/>	Heart <input type="checkbox"/>	<input type="checkbox"/>
Abdom. <input type="checkbox"/>	<input type="checkbox"/>	Abdom. <input type="checkbox"/>	<input type="checkbox"/>	Abdom. <input type="checkbox"/>	<input type="checkbox"/>
Ext.Gen. <input type="checkbox"/>	<input type="checkbox"/>	Ext.Gen. <input type="checkbox"/>	<input type="checkbox"/>	Ext.Gen. <input type="checkbox"/>	<input type="checkbox"/>
Back <input type="checkbox"/>	<input type="checkbox"/>	Back <input type="checkbox"/>	<input type="checkbox"/>	Back <input type="checkbox"/>	<input type="checkbox"/>
Extrem. <input type="checkbox"/>	<input type="checkbox"/>	Extrem. <input type="checkbox"/>	<input type="checkbox"/>	Extrem. <input type="checkbox"/>	<input type="checkbox"/>
Neurol. <input type="checkbox"/>	<input type="checkbox"/>	Neurol. <input type="checkbox"/>	<input type="checkbox"/>	Neurol. <input type="checkbox"/>	<input type="checkbox"/>
<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>	
<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>	
<u>TEACHING</u> 1. Feeding 2. Daily Schedule (Family Member) 3. Teething/Drooling 4. Accident Prevention (foreign bodies) 5. Nursing bottle syndrome  Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. Feeding 2. Anxiety re strange situation 3. Pronounced sucking & drooling 4. Care of teeth 5. Use of cup 6. Impetigo  Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. Use of cup 2. Fears of strangers, separation 3. Accidents (Creeping to outlets, stove, etc.) 4. Need for safe, familiar place to place 5. Bottle mouth syndrome  Appointment to next Clinic _____ Signature: _____	

ADDRESSOGRAPH

**WELL BABY CLINIC  
4-8 MONTHS**

IHS-5-2 (BACK)  
(1/89)