REORDER FROM: FORMGRAPHICS, INC. 800-808-8716

IHS-439
(4/94)

PCC WELL CHILD EXAM RECORD

P.L. 96-511 N.A.

Date _____

Arrival Time _____ : _____ AM PM

Clinic _____

	Affil.	Dis.	Initials
Providers			
Primary Provider			

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)

Remove	Change to Inactive	Change to Active

Parental concerns:

Feeding choice-today		One time entry	Birth order	
Breast only		Mom's name or chart #		
Breast mostly		Birthweight		
½ breast, ½ formula		Age stopped breastfeeding	_____ wks/mths	
Formula mostly		Age started formula	_____ wks/mths	
Formula only		Age started solids	_____ wks/mths	

Development

9 months
___ Feeds self
___ Passes object hand to hand
___ Makes strings of sounds
___ Sits independently
___ Stands, holding on

12 months
___ Plays appropriately with toys (hugs doll)
___ Bangs 2 objects together
___ Uses 1-2 verbal labels for objects or people
___ Stands alone 2 seconds

Any Concerns:

PHYSICAL EXAMINATION

NL	ABNL		NL	ABNL	
0	1	Skin	1	1	Abdomen
0	2	Head	1	2	Pulses: Femorals
0	3	Eyes	1	3	Ortho: hips
0	4	Ears	1	4	Extremities
0	5	Nose	1	5	Spine
0	6	Mouth/Throat	1	6	Neuro
0	7	Neck	1	7	Muscle Tone
0	8	Nodes	1	8	External Genitalia
0	9	Chest	1	9	Other
1	0	Heart	2	0	

AGE ☐ Wks. ☐ Mos.

WT.	☐ GM ☐ KG ☐ LB	% ILE
HT.	☐ CM ☐ IN	% LE
HEAD	☐ CM ☐ IN	% ILE
TEMP (°F)	☐ R ☐ O ☐ A	
PULSE	RESP.	
B/P		
BMI:		

SUBJECTIVE/OBJECTIVE

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

PROBLEM LIST A-Al-C	PROBLEM LIST #	PURPOSE OF VISIT *(DO NOT ABBREVIATE; PRINT ONLY IN THIS SECTION)*

PROBLEM LIST NOTES
STORE NOTE FOR PROB. #

STORE NOTE FOR PROB. #

REMOVE PLAN #

MEDICATIONS

MEDICATIONS/TREATMENTS/PROCEDURES/PATEINT EDUCATION

√	ORDERS	INITIALS
	DTaP#	
	IPV#	
	Hep B#	
	Hep A#	
	HIB#	
	PCV7#	
	MMR#	
	Varicella	
	Influenza	
	Td	
	PPD	mm

GENERAL COUNSELING TASKS DONE:

HR. SS

NAME

B DATE SEX TRIBE

RESIDENCE

FACILITY DATE

NUTRITION COUNSELING TASKS DONE:

REVISIT/ REFERRAL TO: DATE TIME

PURPOSE:

INSTRUCTIONS TO PATIENT:

PROVIDER SIGNATURE:

9-12/6-2005
305995

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IHS-439
(4/94)

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Breast only		*Mom's name or chart #*		
Breast mostly		*Birthweight*		
½ breast, ½ formula		*Age stopped breastfeeding*	_____	wks/mths
Formula mostly		*Age started formula*	_____	wks/mths
Formula only		*Age started solids*	_____	wks/mths

Development

4 months
- ___ Looks for source of sound; interested in sounds around him
- ___ Hands together
- ___ Babbles and coos
- ___ Head steady in supported position

6 months
- ___ Reaches for objects
- ___ Responds to own name
- ___ Vocal imitation, takes turns vocalizing
- ___ Rolls over (both ways)

Any Concerns:

PHYSICAL EXAMINATION

NL	ABNL		NL	ABNL	
0	1	Skin	1	2	Abdomen
0	2	Head	1	3	Pulses: Femorals
0	3	Eyes	1	4	Ortho: hip abduction
0	4	Red Reflex	1	5	Extremities
0	5	Ears	1	6	Spine
0	6	Nose	1	7	Neuro
0	7	Mouth/Throat	1	8	Muscle Tone
0	8	Neck/Nodes	1	9	Symmet.Mvmt.
0	9	Chest	2	0	External Genitalia
1	0	Heart	2	1	Testes descended
1	1	Murmur	2	2	Other

AGE ☐ Wks. ☐ Mos.

WT.	☐ GM ☐ KG ☐ LB	% ILE
HT.	☐ CM ☐ IN	% LE
HEAD	☐ CM ☐ IN	% ILE
TEMP (°F)	☐ R ☐ O ☐ A	
PULSE	RESP.	
B/P		
BMI:		

SUBJECTIVE/OBJECTIVE

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	MMR#	
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	Influenza	
	Td	
	PPD	mm

GENERAL COUNSELING TASKS DONE:

HR. SS

NAME

B DATE SEX TRIBE

RESIDENCE

FACILITY DATE

NUTRITION COUNSELING TASKS DONE:

REVISIT/ REFERRAL TO: DATE TIME

PURPOSE:

INSTRUCTIONS TO PATIENT:

PROVIDER SIGNATURE:

4-6/6-2005
305987

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IHS-439
(4/94)

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Formula only		Age started solids	_____	wks/mths

Development

Birth – 1 month
___ Eye contact
___ Startles to loud noise
___ Equal movement of limbs

2 months
___ Smile responsively
___ Inspects surroundings
___ Vocalizes in play
___ Lifts head

Any Concerns:

PHYSICAL EXAMINATION

NL	ABNL		NL	ABNL	
0	1	Skin	1	6	Cord
0	2	Jaundice	1	7	Abdomen
0	3	Rashes	1	8	Pulses: Femorals
0	4	Head	1	9	Ortho: hip abduction
0	5	Eyes	2	0	Extremities
0	6	Red Reflex	2	1	Spine
0	7	Ears	2	2	Neuro
0	8	Symmetrical	2	3	Reflexes
0	9	Hearing	2	4	Muscle Tone
1	0	Nose	2	5	Symmet. Mvmt.
1	1	Mouth/Throat	2	6	External Genitalia
1	2	Neck/Nodes	2	7	Testes descended
1	3	Chest	2	8	Circumcision
1	4	Heart	2	9	Other
1	5	Murmur			

AGE	☐ Wks. ☐ Mos.	
WT.	☐ GM ☐ KG ☐ LB	% ILE
HT.	☐ CM ☐ IN	% LE
HEAD	☐ CM ☐ IN	% ILE
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GENERAL COUNSELING TASKS DONE:

HR. SS

NAME

B DATE SEX TRIBE

RESIDENCE

FACILITY DATE

NUTRITION COUNSELING TASKS DONE:

REVISIT/ REFERRAL TO: DATE TIME

PURPOSE:

INSTRUCTIONS TO PATIENT:

PROVIDER SIGNATURE:

0-2/6-2005
305979