Belilovsky Pediatrics
523 Oceanview Avenue
Brooklyn, NY 11235
(718) 332-6652

2 WK

ID Sticker:

Patient Name: _____

Date of Birth: _____

Date:_____ **Time:**_____

PEDIATRIC ASSESSMENT 2 WEEKS - WELL VISIT
INFORMANT _____

Interpreter ☐ Yes ☐ No Exposure to Tobacco Smoke ☐ Yes ☐ No Allergies _____

FLACC Behavior pain scale score _____ NIPS _____ Temp _____ Apical_____

Length _____ Weight _____ Resp _____ Head Circumference_____

History of Illness since last visit: _____

Reason for visit:_____

Do you think that your child is developing according to his/her age? ☐ YES ☐ No _____

MA Signature _____

AGE	DEVELOPMENTAL * TASKS ☒ no ☑ yes	☑ NORMAL ☒ ABNORMAL DESCRIBE ON PROGRESS SHEET	DIET ☑ yes ☒ no	ANTICIPATORY GUIDANCE/ IMMUNIZATIONS ☑ yes ☒ no
2 - 4 WEEKS	Equal Movements ☐ (O) Palmar grasp ☐ Raises head when prone ☐ (O) Regards face ☐ Follows to midline ☐ Responds to sound ☐ Mother responds to infant cues ☐	GENERAL APPEARANCE ☐ SKIN ☐ ABD ☐ JAUNDICE ☐ * Umbilicus ☐ HEAD ☐ *Hernia ☐ Fontenels☐ GENITALIA ☐ EYES ☐ *Testes* ☐ *boy* Red Reflex ☐ * *Hydrocele* ☐ *boy* Discharge ☐ Ext. ☐ ENT. ☐ HIPS ☐ LUNGS ☐ NEURO ☐ HEART ☐ Femoral Arteries ☐ * A Normal Check-mark Indicates NOT Present	BREAST ☐ FORMULA ☐ _____ _____ COLIC ☐ VITAMIN ☐ STOOLS_____ _____ FLUORIDE ☐ Prescription ☐ City Water ☐	Car restraints/Crib safety ☐ Sleep position ☐ Babysitters / Pet control ☐ Domestic Violence ☐ Don't leave unattended ever ☐ Avoid exposure to tobacco ☐ Smoke Detector ☐ Cord Care ☐ Sibling Rivalry ☐ Newborn Screen ☐

HE PB Day of Birth or 1st Visit ☐ Yes ☐ NO ☐ NA

Lead RA All Lead Counseling done including Sources and Severe Long-Term Consequences. Literature Made Available. ☐

Follow-up Plan:

*Underlined Milestones should be achieved by at least 90% of children by this age.
If (1) or more "NO's" for underlined items, indicate F/U in plan/orders

** (O) = Objective if possible

RA = Risk Assessment

DATE	TIME	PROGRESS NOTES

Physician Signature:_____

Stamp: