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

4 MOS

ID Sticker:

Patient Name: _____

Date of Birth: _____

PEDIATRIC ASSESSMENT 4 MONTHS - WELL VISIT

INFORMANT _____

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

FLACC Behavior pain scale score _____ Temp _____ Apical _____ Resp _____

Length _____ Weight _____ 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
4 MONTHS	Holds head high ☐ (O) Raises head when prone ☐ (O) Rolls prone to supine ☐ Plays with hands ☐ Grasps ☐ Smiles, coos, laughs, squeals, gurgles ☐ Follows past mid line ☐ (O) No persistent fist clenching ☐ (O)	GENERAL APPEARANCE ☐ HEAD ☐ HEART ☐ Fontenels ☐ Femoral Arteries ☐ SKIN ☐ ABD ☐ EYES ☐ * HERNIA ☐ EOM ☐ GENITALIA ☐ ENT ☐ EXT. ☐ TEETH ☐ HIPS ☐ LUNGS ☐ NEURO ☐ * A Normal Check-mark Indicates NOT Present	BREAST ☐ FORMULA ☐ PUREED SOLID FOOD ☐ FLUORIDE ☐ Prescription ☐ City Water ☐	Observe parent-child interactions ☐ Domestic Violence ☐ Warn re accidental ingestion or aspiration of powders, cleaners, etc. ☐ Small objects out of reach ☐ Day care/ Babysitters ☐ Avoid Tobacco exposure ☐ Update Vaccines ☐ 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: