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

6 MOS

ID Sticker:

Date: _____ **Time:** _____

Patient Name: _____

Date of Birth: _____

PEDIATRIC ASSESSMENT 6 OR 7 MONTHS - WELL VISIT
INFORMANT _____

Interpreter ☐ Yes ☐ No Exposure to Tobacco ☐ 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
6 MONTHS (OR 7TH MO.)	Sits with support ☐ Passes hand to hand ☐ Rolls over ☐ Reaches for toys ☐ Bears weight ☐ Raking hand pattern ☐ Turns to voice ☐ Babbles, laughs ☐ Avoids eye contact ☐	GENERAL APPEARANCE ☐ HEAD ☐ HEART ☐ Fontenels ☐ Femoral Arteries ☐ SKIN ☐ LUNGS ☐ EYES ☐ GENITALIA ☐ EOM ☐ EXT. ☐ STRABISMUS ☐ * HIPS ☐ ENT ☐ NEURO ☐ TEETH ☐ * A Normal Check-mark Indicates NOT Present	BREAST ☐ FORMULA ☐ PUREED SOLID FOOD ☐ _____ _____ _____ _____ STOOLS _____ FLUORIDE ☐ Prescription ☐ City Water ☐	Check home for hazards: ☐ Domestic Violence Hot liquids, electrical outlets, poisons, medicines, dangling cords or table covers Avoid Tobacco exposure ☐ Update Vaccine ☐ Share a toy ☐ Flu Vaccine RA ☐ TB RA ☐ Lead RA All Lead Counseling done including Sources and Severe Long-Term Consequences. Literature Made Available. Blood Levels UTD. ☐ 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
*** Boxed items are abnormal at any age. Indicate follow up

DATE	TIME	PROGRESS NOTES

Physician Signature _____

Stamp: