Recommendations for Preventive Pediatric Health Care

Northwest Primary Care recommends that you bring your child in for regular visits to assist in keeping your child healthy. Well-child visits allow your child's Primary Care Provider (PCP) to monitor your child's growth and development, give any vaccines that are due, and provide a chance to find and treat any concerns early. Well-child appointments are also a good time for you to ask any questions that you have about your child's health and also give the PCP time to discuss age appropriate behavioral issues, including behaviors at the adolescent age.

Visit and Immunization chart

This chart lists important vaccines and tests as well as recommended well-child visits. In addition to theses vaccinations, we recommend all children aged 6 months and older get a flu vaccine every fall.

AGE	Recommended office visits	Pediatric routine visit schedule
Birth	Well-child visit	Newborn blood screen Immunizations may be due
3-5 days	Well-child visit	
7-14 days	Well-child visit	2nd PKU will be due (please bring in baby's paperwork)
1 month	Well-child visit	Height, weight and head circumference check for proper growth
2 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
4 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
6 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
9 months	Well-child visit	Height, weight and head circumference check for proper growth Developmental screening
12 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental screening and blood draw
15-18 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental and Autism screening
2 years	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Autism screening, blood draw and BMI check
3 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
4 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure, vision and hearing check
5 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure, vision and hearing check
6, 8 and 10 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
11 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
12 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
13 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
14 and 15 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
16 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
17 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check

4 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: ____________________

Name: ___________________________________ DOB:__________ Male Female

Physician Signature: ___________________________________

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	**NO**	**YES**
Is your baby crying longer than 30 minutes at a time?	**NO**	**YES**
Do they have severe nasal stuffiness?	**NO**	**YES**
Do you have concerns about skin color or rash?	**NO**	**YES**
Are they wheezing?	**NO**	**YES**
Did they have any problems with previous immunizations?	**NO**	**YES**
Feeding/ Nutrition		
Is your child breast feeding well?	**YES**	**NO**
How often?		
For how long? (minutes)		
Is your child taking formula well?	**YES**	**NO**
How often?		
How many ounces?		
Which formula?		
Are you feeding baby any solid foods?	**NO**	**YES**
Is your baby taking a vitamin supplement?	**NO**	**YES**
Oral Health		
Do parents regularly see a dentist, brush and floss teeth?	**YES**	**NO**
Do you put your baby to bed with a bottle?	**NO**	**YES**
Elimination		
Are they having problems with bowel movements (pooping)?	**NO**	**YES**
Are they urinating (peeing) well?	YES	NO
Sleep		
Do they sleep five or more hours at a time?	**YES**	**NO**
Do you have questions about sleep habits?	**NO**	**YES**
Do you put baby in the crib when drowsy, not fully asleep?	**YES**	**NO**
Does your baby wake at night to eat?	**NO**	**YES**

4 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: ____ DOB:___________

Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	**NO**	**YES**
Siblings adjusting well to the newborn?	**YES**	**NO**
Are you having family stress?	**NO**	**YES**
Do you ever worry your family will go hungry?	**NO**	**YES**
Do you have daycare concerns?	**NO**	**YES**
Development		
Does your baby smile when approached?	**YES**	**NO**
Does your baby coo, babble, and laugh?	**YES**	**NO**
Does your baby have different cries to indicate hunger, tiredness, and pain?	**YES**	**NO**
Does your baby move all extremities well?	**YES**	**NO**
Do they roll?	**YES**	**NO**
Are they able to lift their upper body on their elbows?	**YES**	**NO**
Do they lift their head well when lying on their tummy?	**YES**	**NO**
Do they have good head control?	**YES**	**NO**
Do you hold, cuddle, talk, and play with your baby?	**YES**	**NO**
Safety		
Does your baby sleep on his/her back?	**YES**	**NO**
Does your baby sleep in a bassinet or crib and not parents' bed?	**YES**	**NO**
Do you always keep a hand on baby when placed above the floor?	**YES**	**NO**
Does your baby wear any jewelry including necklaces?	**NO**	**YES**
Do you hold or carry hot liquids around the baby?	**NO**	**YES**
Do you keep plastic bags and latex balloons away from your baby?	**YES**	**NO**
Does your baby ride in a rear facing safety seat, in the back seat?	**YES**	**NO**
Is your baby exposed to anyone who smokes?	**NO**	**YES**
Are there working smoke detectors and carbon monoxide detectors in the home?	**YES**	**NO**
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	**YES**	**NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	**NO**	**YES**
Has a family member or contact had a positive TB skin test (PPD)?	**NO**	**YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	**NO**	**YES**
Has your baby traveled to a high-risk country for more than a week?	**NO**	**YES**