



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 these 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	2 nd 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

2 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
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 your baby anything other than breast milk or formula?	NO	YES
Is your baby taking a vitamin supplement?	YES	NO
Elimination		
Are they having problems with bowel movements (pooping)?	NO	YES
Are they urinating (peeing) well?	YES	NO
Sleep		
Are they sleeping five or more hours at a time?	YES	NO
Do you have questions about sleep habits?	NO	YES
Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	NO	YES
Are the 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

2 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB: _____

Development		
Does your baby smile at the sound of parent's voice?	YES	NO
Does your baby make cooing noises?	YES	NO
Does your baby watch as parent walks across the room?	YES	NO
Does your baby raise their head and chest when lying on tummy?	YES	NO
Does your baby briefly hold objects when placed in their hand?	YES	NO
Safety		
Is your baby swaddled when sleeping?	NO	YES
Does your baby sleep on his/her back?	YES	NO
Does your baby sleep in a bassinet or crib, 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
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