

Patient intake for 2 Month HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:

Verbal Sign language Written Assistive Communication Device

Preferred method of learning:

Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:

No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.

If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always

Barriers to learning? None. If yes, please explain: _____

◆ Do you suspect your baby is in pain?
Staff- Evaluate pain with NIPS tool*

YES

NO

Has the patient been seen elsewhere since their last
clinic visit with us?

YES

NO

If yes, explain: _____

(◆ **Staff- Request Records***)

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently <u>deployed or on extended duty</u> outside of the immediate area?	YES	NO
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	YES	NO

Nutrition

Feeding Method?

Breast Bottle Spoon Cup Other _____

Feeding Type?

Breastmilk Formula Other: _____

Receiving Vitamin-D supplement daily?

Yes No

Developmental Screen

Starting to Smile?	YES	NOT YET
Coos or makes gurgling sounds?	YES	NOT YET
Watches objects as they move?	YES	NOT YET
Moves all arms and legs equally?	YES	NOT YET

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO
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Family history/Surgeries. Check all that apply.

Family History	Patient Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
◆ To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

Please turn the page and complete all EPDS questions. Once you are done, please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition programs! *****

Edinburgh Postnatal Depression Scale (EPDS)

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK (✓)** on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today*. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score*.

Below is an example already completed.

I have felt happy:
Yes, all of the time _____ (0)
Yes, most of the time ✓ (1)
No, not very often _____ (2)
No, not at all _____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
As much as I always could _____ (0)
Not quite so much now _____ (1)
Definitely not so much now _____ (2)
Not at all _____ (3)
2. I have looked forward with enjoyment to things:
As much as I ever did _____ (0)
Rather less than I used to _____ (1)
Definitely less than I used to _____ (2)
Hardly at all _____ (3)
3. I have blamed myself unnecessarily when things went wrong:
Yes, most of the time _____ (3)
Yes, some of the time _____ (2)
Not very often _____ (1)
No, never _____ (0)
4. I have been anxious or worried for no good reason:
No, not at all _____ (0)
Hardly ever _____ (1)
Yes, sometimes _____ (2)
Yes, very often _____ (3)
5. I have felt scared or panicky for no good reason:
Yes, quite a lot _____ (3)
Yes, sometimes _____ (2)
No, not much _____ (1)
No, not at all _____ (0)
6. Things have been getting to me:
Yes, most of the time I haven't been able to cope at all _____ (3)
Yes, sometimes I haven't been coping as well as usual _____ (2)
No, most of the time I have coped quite well _____ (1)
No, I have been coping as well as ever _____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
Yes, most of the time _____ (3)
Yes, sometimes _____ (2)
No, not very often _____ (1)
No, not at all _____ (0)
8. I have felt sad or miserable:
Yes, most of the time _____ (3)
Yes, quite often _____ (2)
Not very often _____ (1)
No, not at all _____ (0)
9. I have been so unhappy that I have been crying:
Yes, most of the time _____ (3)
Yes, quite often _____ (2)
Only occasionally _____ (1)
No, never _____ (0)
10. The thought of harming myself has occurred to me: *
Yes, quite often _____ (3)
Sometimes _____ (2)
Hardly ever _____ (1)
Never _____ (0)

TOTAL YOUR SCORE HERE ►

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

(Below for Office Staff)

Weight: _____ kg

Length: _____ cm

Head Circumference: _____ cm

Heart Rate: _____ bpm

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

2 Month Health Supervision

Your child's growth:

Weight: _____ lb. Percentile: _____

Length: _____ in. Percentile: _____

Head Circumference: _____ cm. Percentile: _____

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process



Parental Well-Being

- Taking care of yourself helps you take care of your baby.
- Call for help if you feel sad or blue

Click on me to go to the
"HealthyChildren.org" Website!
An American Academy of Pediatrics (AAP)
guide to your child's milestones, growth
and development. Search by age.



Infant adjustment

- Put baby to sleep on their back in a crib or bassinet.
- Encouraged tummy time-put your baby on their tummy when awake and you are there to watch.
- Crying is normal and may increase when your baby is 6-8 weeks old.
- When your baby is crying, comfort them by talking, patting, stroking, and rocking.
- *Never shake your baby.*
- If you feel upset, put your baby in a safe place; call for help.

Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Keep hanging cords or strings away from your baby.
- Keep a hand on your baby when changing clothes or the diaper to prevent falls.

Feeding

- Feed your baby only breastmilk or iron-fortified formula in the first 4-6 months of life.
- Breastfeed or bottle-feed 8-12 times per day.
- Feed your baby when you see signs of hunger, such as putting hand in mouth or sucking, rooting or fussing.
- End feeding when you see signs your baby is full, such as turning away, closing the mouth, or relaxed arms and hands.

Immunizations

- Pediarix #1 (Hepatitis B, Diphtheria, Tetanus, Pertussis, Polio)
- Pedvax #1 (Haemophilus Influenza Type B)
- Prevnar20 #1 (Streptococcal pneumoniae)
- Rotarix oral #1 (Rotavirus)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: <https://centercitypediatrics.com/wait-worry-panic/>

Medications: See attached weight-based Acetaminophen (Tylenol) dosing chart.

Next health supervision appointment: 4 months of age.

Patient specific guidance:
