# CHRONOLOGICAL RECORD OF WELL-BABY CARE

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

| **SIGNIFICANT NEONATAL HX** | **DOB** *(YYYYMMDD)* | **WEIGHT** | **HEIGHT** | **PKU** |
|---|---|---|---|---|

| | | |
|---|---|---|
| DATE OF VISIT *(YYYYMMDD)* | | |
| AGE | | |
| WEIGHT | | |
| HEIGHT | | |
| HEAD CIRCUMFERENCE | | |
| **SUBJECTIVE (HISTORY)** | | |
| 1. FEEDING<br>2. FORMULA/BREAST<br>SOLIDS<br>VITAMINS/FLOURIDE<br>2. ELIMINATION<br>3. GROWTH AND DEVELOPMENT<br>4. PARENTAL CONCERNS | | |
| **OBJECTIVE**<br>**PHYSICAL EXAM** | | |
| NUTRITION | | |
| HEAD/FONTANEL | | |
| EENT | | |
| NECK/CLAVICLES | | |
| LUNGS | | |
| HEART | | |
| ABDOMEN | | |
| GENITALIA/HERNIA | | |
| HIPS/SPINE | | |
| EXTREMITIES | | |
| SKIN | | |
| NEUROLOGICAL | | |
| **ASSESSMENT** | | |
| **PLANS AND COUNSELING** | | |
| SAFETY<br>FEEDING<br>GROWTH AND DEVELOPMENT<br>IMMUNIZATION<br>NEXT VISIT *(YYYYMMDD)* | | |
| | EXAMINED BY | EXAMINED BY |

| PATIENT's IDENTIFICATION (Name, last, first, middle, grade, date, hospital or medical facility) | REMARKS |
|---|---|
| | |

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