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		(YYYYMMDD)	WEIGHT	HEIG		PKU			
DATE OF VISIT (YYYYMMDD)									
AGE									
WEIGHT									
HEIGHT									
HEAD CIRCUMFERENCE									
SUBJECTIVE (HISTORY)		-							
1. FEEDING									
2. FORMULA/BREAST									
SOLIDS									
VITAMINS/FLOURIDE									
2. ELIMINATION									
3. GROWTH AND DEVELOPMENT									
4. PARENTAL CONCERNS									
OBJECTIVE PHYSICAL EXAM									
NUTRITION									
HEAD/FONTANEL									
EENT									
NECK/CLAVICLES									
LUNGS									
HEART									
ABDOMEN									
GENITALIA/HERNIA									
HIPS/SPINE									
EXTREMITIES									
SKIN									
NEUROLOGICAL									
ASSESSMENT									
PLANS AND COUNSELING									
SAFETY		1							
FEEDING									
GROWTH AND DEVELOPMENT									
IMMUNIZATION									
NEXT VISIT (YYYYMMDD)									
		EXAMINED BY	(EXAMINED BY				
PATIENT'S IDENTIFICATION (Name, la	ast. firs	t, middle. grade	REMARK	3	1				
date, hospital or medical facility)		,, grado		-					

SIGNIFICANT NEONATAL HX	DOB	(YYYYMMDD)	WEIGHT	HEIG	ŧΗТ	РКО
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DATE OF VISIT (YYYYMMDD) AGE		+				
WEIGHT		+				
HEIGHT					-	
HEIGHT HEAD CIRCUMFERENCE					+	
		+			+	
SUBJECTIVE (HISTORY)		-				
1. FEEDING						
2. FORMULA/BREAST						
SOLIDS						
 2. ELIMINATION 3. GROWTH AND DEVELOPMENT 						
 GROWTH AND DEVELOPMENT PARENTAL CONCERNS 						
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OBJECTIVE PHYSICAL EXAM						
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NECK/CLAVICLES						
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HEART					<u> </u>	
ABDOMEN					1	
GENITALIA/HERNIA					1	
HIPS/SPINE					1	
EXTREMITIES					1	
SKIN					1	
NEUROLOGICAL						
ASSESSMENT						
PLANS AND COUNSELING						
SAFETY		-				
FEEDING						
GROWTH AND DEVELOPMENT						
IMMUNIZATION						
NEXT VISIT(YYYYMMDD)						
		EXAMINED BY			EXAMINED BY	
PATIENT'S IDENTIFICATION (Name, la date, hospital or medical facility)	ast, firs	it, middle, grade,	, REMARKS			
date, nospital of medical facility)						