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NINCDS COLLABORATIVE
PERINATAL PROJECT
A User's Guide to the Project and Data

Volume II: Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part F: Pediatric and Neurological Exams, Four Months - One Year, Physical Growth Measurements, Interval History, and Summary of Illness or Hospitalization

December 1983

Prepared for
the National Institute of Neurological
and Communicative Disorders and Stroke
under Contract 2311105150

Battelle
Pacific Northwest Laboratories

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NINCDS COLLABORATIVE PERINATAL PROJECT: A USER'S GUIDE TO THE PROJECT AND DATA

Volume II. Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part F. Pediatric and Neurological Exams, Four Months - One Year, Physical Growth Measurements, Interval History, and Summary of Illness or Hospitalizations

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INTRODUCTION

DOCUMENT OBJECTIVES AND READER ASSUMPTIONS

Volume II, Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File, provides researchers with detailed documentation for how data were collected, coded and stored on the data base. Volume II will help investigators decide: if data were collected in a suitable way for addressing particular research questions; if revision of forms affected the collection of specific data items; if data were coded on raster, variable or work files, or are available only on microfilm. The reader is assumed to be the principal investigator for a project in which data from the data base will be used.

DOCUMENT STRUCTURE

Because of its size, this volume is divided into ten separate parts, each containing material on a group of forms related by subject. Each part groups together similar study forms. Generally, a part covers a single time period. The parts do not correspond exactly to the hierarchical classification structure described in Volume I. The parts of Volume II include:

A. Prenatal Record and Medical History
B. Labor and Delivery
C. Pathological Exams and Autopsies
D. Family and Socioeconomic History
E. Neonatal Exams and Observations
F. Pediatric and Neurological Exams, Four Months - One Year
G. Pediatric Neurological Exams, Seven Years
H. Psychological Exams, Eight Months
I. Psychological Exams, Four Years and Seven Years
J. Speech, Language and Hearing Exams, Three Years and Eight Years (Final)

This part of Volume II contains Part F: Pediatric and Neurological Exams, Four Months - One Year and includes Forms PED-10, PED-11, PED-12, PED-14, PED-20 and PED-29.

To allow easy access to the data as they appear on the master file, all documentation for each form or form grouping representing a card series on the master file is identified by form number appearing at the bottom of each page. Forms are arranged in what may appear to be illogical numerical order in some cases, but the arrangement presented here ties forms and their revisions together and allows an investigator to trace an item through all revision cycles. Thus, in Part A of Volume II, 08-42 follows 05-9 and 08-10 appears next to 08-44 and 05-45. (For an explanation of how the master file was organized to result in this ordering, see the next section of the Introduction.)

All material related to a form is organized as a single unit within each part of Volume II. The material included for each form is given below in the order it appears:

- Descriptive Summary of Form. Includes purpose of form, history of use, revisions and location of records stored on Master File. A table is provided for each form (except those on microfilm only) showing the number of records available for each revision.
- Data Items Referencing Form. A list of all data items in computer files originating from form. List ordered by data item identification with reference to item number on form.
- Form. Copy of last revision of form.
- Form item numbers linked to data items. A list organized by form item numbers of all computerized data items originating from the form.
- Definition of codes. Coding instructions detailing the codes assigned to each computerized data item from the form.
- Master file card image. Illustrates transfer of data on form to Master File card.
- Instructions for Completing Form. The instructions used by study personnel to complete the form for each case.
- Earlier Forms or Manuals. Copies of earlier versions of forms or manuals that were used during the study.

MASTER FILE ORGANIZATION AND REVISION OF FORMS

For a understanding of how the master file was organized should aid investigators who want to trace the entry of data into computerized study files. The numbering system used both on forms and cards provides information on how data may be retrieved from the master file.

Forms

The first forms used in the study were the OB forms; as a consequence, this group of forms underwent the most revision. At first glance, it appears that forms disappear from the file and reappear in strange or bewildering places. In actuality, revisions were made according to a specific method.

Two types of revision and subsequent recodes appear in the master file, both of which appear in the OB series. In the first type of revision, radical changes in the concept of a form created a need for new coding in the computer file. Form OB-9, for example, was replaced by forms OB-40 (an optional form retained by the institution), OB-42, and OB-43 in April 1962. Data for earlier patients were recorded on OB-9 and entered on cards 1309, 2309, 3309 and 4309 of the master file; after April 1962, data was recorded on OB-42 and OB-43 and were entered on cards 0342, 1343 and 2343 of the master file.

In the second type of revision, the Collaborative Perinatal Task Force considered revisions important enough to warrant the distinction of a new form number, but considered the data for both forms to be similar enough to allow combining of data from both the old and new forms on the same card series. An example of this type of revision is form OB-35, replaced by OB-57 in April 1962. Records for both OB-35 and OB-57 are entered on cards 0357, 1357, 2357, 3357, 4357, and 5357 in the master file.

In assigning numbers to forms and their revisions, designers of the study followed a plan: prenatal records, history, and summaries of the prenatal period received numbers 1 through 19; when revised, these forms were assigned numbers in the forties. Labor and hospital records appeared on the 30 series of forms. When these forms were revised, they were assigned numbers in the fifties. Some OB data in the master file were abstracted by NINCDS staff members from forms filled out at the hospital. Cards derived from this procedure were designated as coming from forms ABH-49, 50 and 51 (which were actually ABSTRACT SHEETS). Autopsy protocol and laboratory exams of the placenta were recorded on forms PATH-1, PATH-2 and PATH-3.

Forms for recording family health history and genetic information during pregnancy also received a fair amount of revision. Early records appear on forms FHH-1,2,3 and 4. With revisions in April 1963, form SE-1 replaces part of FHH-1 and FHH-3; FHH-2, FHH-4 and parts of FHH-1 and FHH-3 were replaced by

forms GEN-5 through GEN-8 in May 1961. Form FHH-9, initiated in November 1965 for collection of socioeconomic data at time the child was seven years of age, was not replaced or revised.

The PED series of forms underwent little revision. Records for newborn babies appeared in PED-1 through PED-8; records for children up to age one and interval records were placed on PED-10 through PED-29. Seven year records were included in the series numbered PED-74 and up. Only one pediatrics form was radically revised: PED-7 was replaced by PED-8 in March 1963.

No replacements occur in the PS series, where results of psychological and speech, language and hearing tests were recorded. The PS forms are divided into distinct groups based on time of testing and subject of testing. Psychological testing occurred at 8 months, 4 years and 7 years; speech, language and hearing exams were administered at ages 3 and 8. Only the 8 month psychological examination underwent substantial revisions.

Master File Card Number and
NINDB Case Number Rationale

Computer cards for each NCPP study form are numbered to reflect their origin and possible revisions. Card numbers are assigned to identify the type of data (subject), the presence of multiple cards in a series, NCPP study form and form revisions. The first five digits of each card on the master file are the card number. The study forms and card numbers are given in Figure 1.

The first fourteen columns of each master file computer card contain the master file card number and the NINDB case number. Table 1 identifies the function of each of these columns.

Column 1 identifies multiple cards in a series. It contains a zero for cards unique to a particular form (that is, no other cards are present), for example OB-3, or for cards where repetitive data are contained. Cards for OB-2 are an example of this second type; no new categories of information are included on successive cards, but previous births in excess of four must be recorded on an add-on card. For card series where data entered are unique to a card and more than one card is required to complete the series, a "1" is used to designate the first card, for example OB-5. OB-57, PATH-2 and PED-14 are exceptions to these rules.

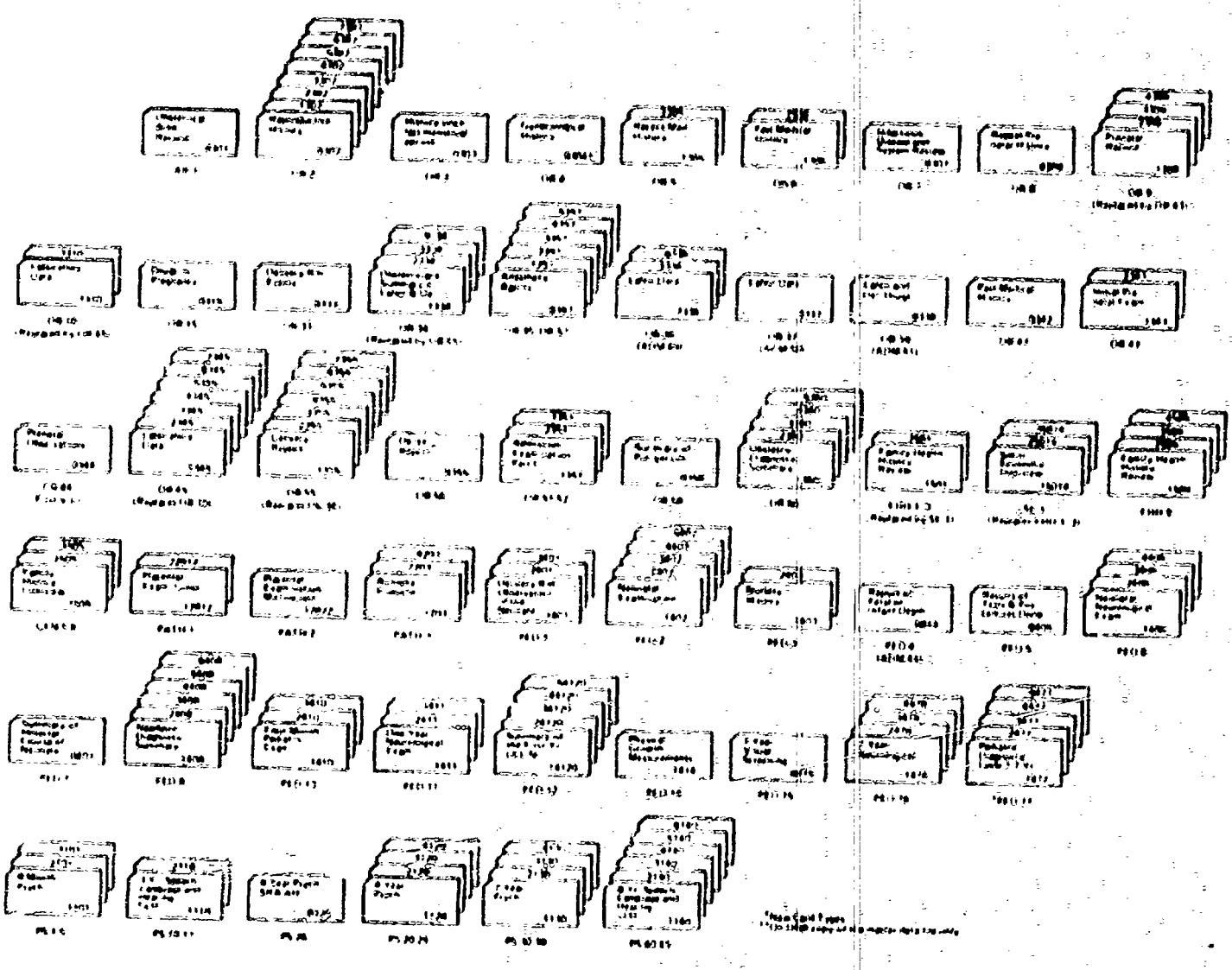

FIGURE 1. Cards on the Master Data File

TABLE 1. Derivation of Master File Card Number and NIMDB Case Number.

Contents	Columns
Master File Card Number	
card identifier	1
general subject matter	2
form number	3-4
revision code	5
NIMDB Case Number	
collaborating institution	6-7
type of patient selection	8
gravida identification number	9-12
order of the pregnancy	13
identifies child or gravida	14

The second digit on the card reveals the general subject matter covered by data on the card. All cards containing information pertaining to obstetrics, for example, are designated by a "3" in column 2; family histories are designated by a "5"; pathology with a "2"; pediatrics, with a "4"; and psychological testing with a "1".

Columns three and four reveal the form number. In the case of forms where old and new forms having different numbers are included together, the number of the latest form appears on the raster file. This rule does not apply to data abstracted from several forms by NIMCDS staff (ADM forms).

Column 5 of the card contains a revision code indicating which form or combination of forms was used in arriving at data on a particular card. A typical card will have one to three revision codes, with a zero indicating the first version of a form and "1", "2", and "3" indicating later revisions. As a rule, revision codes used on cards differ from card to card; investigators should check the definition of codes provided in Volume II to determine the meaning of revision codes used.

Each woman and child studied in the project received a unique case number (NIMDB case number) composed of nine digits, recorded in columns 6 through 14 of all master file cards. The case number identified the institution, the mother and the child. The first two digits represented the collaborating institution (see Table 2). The third digit indicated the type of patient

selection. A "1" was used for patients selected for the central core study; a "6" indicated that a patient had been transferred from one institution to another, and a "7" indicated that the patient was part of a special study undertaken by the collaborating institution. The fourth through seventh digits were used to identify the gravida, while the eighth digit identified the order of the pregnancy of a given gravida in the project. The ninth digit was used to identify the gravida or child of the pregnancy; "9" indicated the gravida, "0" indicated the child of a single birth, "1" indicated the first child of a multiple birth, "2" indicated the second child of a multiple birth, etc.

TABLE 2. Collaborating Institutions and Their Code Number (Columns six and seven of all master file cards.)

[illegible] - Boston, Massachusetts
Harvard Medical School
Boston Lying-in Hospital
Children's Hospital Medical Center

10 - Buffalo, New York
University of Buffalo
Children's Hospital

15 - New Orleans, Louisiana
Charity Hospital
Tulane University School of Medicine Medical Center
Louisiana State University

1 - New York, New York
Columbia University College of Physicians & Surgeons
Columbia-Presbyterian Medical Center

37 - Baltimore, Maryland
The Johns Hopkins University School of Medicine
The Johns Hopkins Hospital

[illegible] - Richmond, Virginia
Virginia Commonwealth University
Medical College of Virginia

55 - Minneapolis, Minnesota
University of Minnesota Hospital
Health Sciences Center

55 - New York, New York
New York Medical College
Metropolitan Hospital

60 - Portland, Oregon
University of Oregon
Medical School

64 - Philadelphia, Pennsylvania
University of Pennsylvania
Pennsylvania Hospital
The Children's Hospital of Philadelphia

78 - Providence, Rhode Island
Brown University
Child Study Center

81 - Memphis, Tennessee
University of Tennessee
College of Medicine
Collier Hospital

Data Item Identification and Naming

The NCPP data base contains over [illegible] different data items and blank filler locations on computer files. We have assigned each of these a unique identification and a terse, stylized name. Because names were chosen to facilitate use of this guide, they do not duplicate names used by NINDS during the active phase of the project. Users should consult appropriate documentation before using data items from the master, variable or work files (Volumes II, III and IV).

The data item identifiers consist of 11 characters. At the far left are four unique numbers that were assigned sequentially. The next character is always a period and is followed by up to six characters. For data items on the master file, these characters describe the data collection form from which a data item was derived; for data items on the variable (VAR) or work (WK) files, these characters indicate the appropriate file. If the right side is less than six characters, periods are inserted as shown in these examples:

[illegible]..[illegible]-[illegible]	an item from [illegible]-[illegible] on the master file
[illegible].PATH-[illegible]	an item from PATH-[illegible] on the master file
[illegible]....VAR	an item on the variable file
[illegible]...[illegible]-[illegible]	an item on work file [illegible] Rupture of Membranes

We assigned the numbers sequentially as they appear in Volume V. For the master file, we followed the order in which the cards would be found within an [illegible] case. All card columns are accounted for by one of our data item identifications. For the variable and work files, the numbers were assigned in the order that data items appear within a case.

We categorized each data item according to the person to which the data refer, by the time of measurement and/or the time to which the item applies and by general type or subject area (Table [illegible]). Then we assigned names to the data items using the following guidelines:

- [illegible] categories [illegible] stand alone - they must [illegible] the data item out of context.
- The first word in the data item name had to be an important or key word with all names [illegible] alphabetically as in Volumes [illegible] and VII. Thus "cry, abnormal" was used rather than "abnormal cry" because a

researcher is more likely to look for this item under "C" than under "A" in an alphabetic list.

- Secondary key words were preceded with a semicolon to facilitate preparation of the permuted index. For example, "abruptio; placenta" will be found under both the "A" and "P" portion of Volume VI.

- Qualifying words are delimited by commas and will not appear as keywords in Volume VI. Thus "abruptio; placenta, degree" will not be found in the "D" section.

- If medical terminology or usage has changed since the study was conducted, current terms may be included and will be enclosed in brackets. Thus "coagulist; [Down's syndrome]" will appear under both the "D" and "S" portions of Volume VI.

- If measurement units are associated with a data item name, they are enclosed in parentheses and placed at the end of the name as in "Birthdate (yr)."

- The categories (person, time and subject) are appended to the right of the data item name.

Definitions for each category used in naming data items are given in Table 4 at the end of this introduction. Additional information is found in Chapter 4 of Volume I.

Data item names thus assigned are terse and highly stylized; as we have already indicated, they are not the names used by NIHS during the active phase of the project. Our aim was to develop standardized names that would stand alone. These names are intended to facilitate a user's search for data items potentially useful in a research project. Before an item is used, a researcher should consult its complete description. For a data item from the master files, e.g., B80..08-34, the data item should be traced to the appropriate study form, e.g., 08-34, located in Volume II. A variable file data item, e.g., 8213....WA9, is traced to Volume III, where it is defined and its original source given. A data item from a work file is traced to Volume IV for its description.

Some data items contained in the indexes may include the notation "DO NOT USE." These items are either inaccurate or an alternative data item is available that gives better information. Users will find more appropriate data items by consulting one of the indexes to the data items (Volumes V, VI and VII).

Tables of Data Items: Column Headings

For each form, two sets of computer generated pages list all data items in either the master, variable or work files derived from this form. These lists enable a user to trace form items to computerized data items listed in other volumes of the User's Guide and vice versa. The computer listings have the following information.

Column Heading	Description
DATA ITEM ID	A unique identifier for this data item. See Data Item Identification and Naming above for details.
FORM ITEM [illegible]	An identifier used on the [illegible] study form to identify the question or group of questions which was used to generate this data item.
CARD NUM	Identifies the master file card on which this data item is located. See Master File Card Number and [illegible] Number Rationale above for a description of card number.
BEGIN	Beginning card column for this data item.
END	Ending card column for this data item.
DATA ITEM NAME	Terse stylized name for this data item. See Data Item Identification and Naming above for details.

[illegible]

By examining the tables provided for each, investigators will be able to determine which computer files contain data of interest. For data contained in the variable file, see Volume III of this Guide; for data contained in work files, see Volume I[illegible].

TABLE 3. Abbreviations for Person, Time and Subject Categories

Person	Time	Subject
Mother	General	Administrative
Father	Preconception	Anesthesia
Placenta	Registration	Clin. Impression
Fetus	Prenatal	Clinical Lab
Child	Admission	Current Pregnancy
M Surrogate	Intrapartum	Environ. Exposure
Family	Delivery	Events
Sibship	Post Partum	Hearing
	Neonatal	Hospitalizations
	Four month	Language
	Eight month	Linkage
	One year	Malformations
	Three year	Diag. & Cond.
	Four year	Med. History
	Seven year	Medications
	Eight year	Neurological Exam
		Observations
		Pathology
		Physical Exam
		Procedure
		Psych. Exam
		Reproductive Hist.
		Serology
		Socioecon. Info
		Speech
		Vision
		Work History
		X-ray
		Summary
		Gyn. History
		Special Studies
		Fam/Genetic Hist.
		SLH Exam

TABLE 4. Definition of Person, Time and Subject Categories

PERSON	DEFINITION
Mother	Study registrant bearing the "study pregnancy"; biologic mother of the "study child"; gravida.
Father	Biologic father of the study child or study pregnancy; in the case of sociocconomic data, this category may indicate either the "father of baby" (not necessarily husband of the mother) or the "husband" (not necessarily related biologically to the study child).
Placenta	The organ of metabolic and gaseous interchange between the fetus and mother; also included in this category are gross and microscopic pathologic data from examination of the umbilical cord.
Fetus	Conceptus; the product of conception including the embryonic stage, i.e., from conception to the moment of birth.
Child	Product of the study pregnancy from the moment of birth onward; study child.
" Surrogate	Person or persons substituting for the mother of a study child, e.g., adoptive parents, foster parents or guardian.
Family	Person or persons biologically related to the mother or father of the study child.
Sibship	Child or children having one or both of the same biologic parents as the study child; siblings; half siblings; full siblings.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

TIME	DEFINITION
General	Data with no pertinent time period or data pertaining to more than one time period.
Preconception	Data pertaining to the period prior to conception of the study pregnancy.
Registration	Data collected at the time of study mother's registration in the study.
Prenatal	Data pertaining to the period from conception of the study pregnancy to delivery of the study child.
Admission	Data collected at the time of study mother's admission to the hospital for delivery of the study child.
Intrapartum	Data pertaining to the period from admission for delivery or onset of labor to delivery of the study child.
Delivery	Data pertaining to the time period during which delivery of the study child occurred.
Post Partum	Data pertaining to the study mother; collected during the period immediately following birth of the study child.
Neonatal	Data pertaining to the study child during the period from birth to one month of age; the majority of these data were collected prior to or at the time a study child was discharged from the hospital.
Four Month	Data collected at the time of the four month examination of the study child.
Eight Month	Data collected at the time of the eight month examination of the study child.
One Year	Data collected at the time of the one year examination of the study child.
Three Year	Data collected at the time of the three year examination of the study child.
Four Year	Data collected at the time of the four year examination of the study child.
Seven Year	Data collected at the time of the seven year examination of the study child.
Eight Year	Data collected at the time of the eight year examination of the study child.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

SUBJECT	DEFINITION
Administrative	Data pertaining to the administrative aspects of the study.
Anesthesia	Data on medications and procedures used to obtain anesthesia.
Clin. Impression	Impression of abnormality or dysfunction gained by an examiner following evaluation of clinical signs and symptoms and including a subjective component.
Clinical Lab	Data obtained from laboratory examination of clinical specimens.
Current Pregnancy	Personal data and medically relevant information pertaining to the study pregnancy for which the mother is enrolled.
Environ. Exposure	Data on exposure to occupational or other environmental entities or hazards.
Events	Data related to a specific event, occurrence or incidence.
Hearing	Data obtained from examination and testing of hearing function.
Hospitalizations	Data on specific hospital admissions or the number of hospitalizations.
Language	Data obtained from examination and testing of language function.
Linkage	Data on the genetic relationships of family members to the study mother, father or child.
Malformations	Data on the conditions in which failure of normal development has resulted in abnormal physical traits existing at the time of birth.
Diag. & Cond.	Data on specific diagnoses or conditions obtained from past medical history or examination during the study.
Med. History	Data obtained from the study participant or medical records relevant to past or current medical diagnoses or conditions.
Medications	Data on drugs or medications used.
Neurological Exam	Data obtained from observation and physical examination of the central nervous system.
Observations	Data obtained from observations not categorized elsewhere.
Pathology	Data obtained from clinical and anatomical pathological examination.
Physical Exam	Data obtained from physical examination of the study participant.
Procedure	Data relating to specific procedures performed on the study participant prior to or during the period of enrollment in the study.
Psych. Exam	Data obtained from the psychological examinations and observations.

TABLE 4. Definition of Person, Time and Subject Categories. (Cont.)

SUBJECT	DEFINITION
Reproductive Hist.	Data pertaining to the outcome of pregnancies prior to and or during the period of enrollment in the study.
Serology	Data obtained from the laboratory examination of serum by specific immunologic methods.
Socioecon. Info	Data related to the social and economic characteristics and environment of the study participant.
Speech	Data obtained from examination and observation of speech function.
Vision	Data obtained from examination of the eyes.
Work History	Data pertaining to occupation and employment prior to and during the period of enrollment in the study.
X-Ray	Data on diagnostic x rays and diagnostic or therapeutic radiological procedures.
Summary	Data presented as a summary of data collected and recorded elsewhere.
Gyn. History	Medical history specifically related to the female genital tract, reproductive physiology and endocrinology.
Special Studies	Data pertaining to participation in other special organized studies conducted during the period of enrollment in the study.
Fam/Genetic Hist.	Data on the medical histories of family members genetically related to the study child.
SLH Exam	Data obtained from the speech, language and hearing examinations not specifically or exclusively related to one of these areas.

CONTENTS

PED-10 Four-Month Pediatric Examination

Purpose of the four-month pediatric exam was to detect evidence of injury or disease in the infant. Particular emphasis was placed on differentiating conditions related to the prenatal or perinatal period from conditions acquired in the postnatal period. Date of implementation of PED-10 into the study is uncertain, as the first version of the form was undated. Revision in October 1960 affected the form by changing the order of items, changing wording and by adding some items. Data from PED-10 were recorded on three cards in the master file (Table PED-10.1).

TABLE PED-10.1 Cards and Data Records by Revision for Form PED-10

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-10: Weight, Length, Conditions, Fontanelles	1410		
		0	5,956
		1	40,830
			46,786
PED-10: Musculo-Skeletal System, Tone, Motor Skills	2410		
		0	5,956
		1	40,867
			46,823
PED-10: Eyes, Movements, Moro Response	3410		
		0	5,954
			5,954
	total for form		99,563

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4297.....		1410	1	5	Card number (sequence, form type, form number, revision number)
4298.....		1410	6	14	NINDS case number
4299.PED-10	5	1410	15	16	Age (wks)
4300.PED-10	4	1410	17	18	Form PED-10 date (mo)
4301.PED-10	4	1410	19	20	Form PED-10 date (day)
4302.PED-10	4	1410	21	22	Form PED-10 date (yr)
4303.PED-10	1	1410	23	24	Birth date (mo)
4304.PED-10	1	1410	25	26	Birth date (day)
4305.PED-10	1	1410	27	28	Birth date (yr)
4306.PED-10	6	1410	29	30	Weight (lbs)
4307.PED-10	6	1410	31	32	Weight (oz)
4308.PED-10	7	1410	33	34	Length: body (cm)
4309.PED-10	7	1410	35	36	Length, lower segment (cm)
4310.PED-10	8	1410	37	38	Head circumference (cm)
4311.PED-10	9	1410	39	40	Chest circumference (cm)
4312.PED-10	10	1410	41	42	Respiratory rate
4313.PED-10	11	1410	43	45	Heart rate
4314.PED-10	12	1410	46	48	Blood pressure, systolic
4315.PED-10	13	1410	49	49	Skin appearence
4316.PED-10	14	1410	50	50	Subcutaneous tissue
4317.PED-10	15	1410	51	51	Hair; nails
4318.PED-10	16	1410	52	52	Head appearence
4319.PED-10	18	1410	53	53	Fontanelles, anterior, condition
4320.PED-10	18	1410	54	55	Fontanelles, anterior, A-P size (cm)
4321.PED-10	18	1410	56	57	Fontanelles, anterior, lateral (cm)
4322.PED-10	18	1410	58	58	Fontanelles, anterior, tension (cm)
4323.PED-10	19	1410	59	59	Fontanelles, posterior, condition
4324.PED-10	19	1410	60	61	Fontanelles, posterior, A-P size (cm)
4325.PED-10	19	1410	62	63	Fontanelles, posterior, lateral (cm)
4326.PED-10	19	1410	64	64	Fontanelles, posterior, tension (cm)
4327.PED-10	22	1410	65	65	Facies
4328.PED-10	23	1410	66	66	Movements: face
4329.PED-10	27	1410	67	67	Eye, right
4330.PED-10	28	1410	68	68	Eye, left
4331.PED-10	30	1410	69	69	Ear, right
4332.PED-10	31	1410	70	70	Ear, left
4333.PED-10	32	1410	71	71	Nose; mouth; pharynx
4334.PED-10	33	1410	72	72	Neck
4335.PED-10	34	1410	73	73	Thorax
4336.PED-10	35	1410	74	74	Respirations
4337.PED-10	36	1410	75	75	Lungs
4338.PED-10	37	1410	76	76	Heart

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4339.PED-10	18	1410	77	77	Pulses: femoral
4340.....		1410	78	78	Blank
4341.PED-10		1410	79	80	Length, upper segment (cm)
4342.....		2410	1	5	Card number (sequence, form type, form number, revision number)
4343.....		2410	6	14	NIMH case number
4344.PED-10	5	2410	15	16	Age (wks)
4345.PED-10	41	2410	17	17	Lymph: nodes
4346.PED-10	42	2410	18	18	Abdomen and contents
4347.PED-10	43	2410	19	19	Liver
4348.PED-10	44	2410	20	20	Spleen
4349.PED-10	45	2410	21	21	Kidneys
4350.PED-10	46	2410	22	22	Genitalia
4351.PED-10	47	2410	23	23	Reflex: anal sphincter
4352.PED-10	48	2410	24	24	Spine
4353.PED-10	50	2410	25	25	Musculoskeletal: shoulder girdle
4354.PED-10	51	2410	26	26	Musculoskeletal: arms: wrists
4355.PED-10	52	2410	27	27	Musculoskeletal: hands
4356.PED-10	53	2410	28	28	Musculoskeletal: pelvic girdle
4357.PED-10	54	2410	29	29	Musculoskeletal: legs: ankles
4358.PED-10	55	2410	30	30	Musculoskeletal: feet
4359.PED-10	56	2410	31	31	Motor activity
4360.PED-10	61	2410	32	32	Tone: extremity, upper, bilateral
4361.PED-10	61	2410	33	33	Tone: extremity, upper, right
4362.PED-10	61	2410	34	34	Tone: extremity, upper, left
4363.PED-10	62	2410	35	35	Tone: extremity, lower, bilateral
4364.PED-10	62	2410	36	36	Tone: extremity, lower, right
4365.PED-10	62	2410	37	37	Tone: extremity, lower, left
4366.PED-10	63	2410	38	38	Tone: neck flexor, bilateral
4367.PED-10	63	2410	39	39	Tone: neck flexor, right
4368.PED-10	63	2410	40	40	Tone: neck flexor, left
4369.PED-10	64	2410	41	41	Tone: neck extensor, bilateral
4370.PED-10	64	2410	42	42	Tone: neck extensor, right
4371.PED-10	64	2410	43	43	Tone: neck extensor, left
4372.PED-10	65	2410	44	44	Tone: trunk, bilateral
4373.PED-10	65	2410	45	45	Tone: trunk, right
4374.PED-10	65	2410	46	46	Tone: trunk, left
4375.PED-10	66	2410	47	47	Grasp: palmar
4376.PED-10	67	2410	48	48	Grasp: plantar
4377.PED-10	68	2410	49	49	Reflex: patellar jerk
4378.PED-10	69	2410	50	50	Reflex: ankle jerk
4379.PED-10	70	2410	51	51	Clonus: ankle
4380.PED-10	71	2410	52	52	Hearing response
4381.PED-10	72	2410	53	53	Stepping response

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM ID	TYPE IN FORM	CARD NUM	FROM	TO	DATA TYPE NAME
4382.PED-10	73	2410	51	54	Placing response
4383.PED-10	74	2410	55	55	Response to mirror image
4384.PED-10	77	2410	56	56	Response to red ring
4385.PED-10	78	2410	57	57	Motor skills, supports weight
4386.PED-10	79	2410	58	58	Motor skills, prone
4387.PED-10	80	2410	59	59	Motor skills, sitting head erect
4388.PED-10	81	2410	60	60	Motor skills, sitting spine erect
4389.PED-10	82	2410	61	61	Hands, predominant position
4390.PED-10	83	2410	62	62	Cry
4391.PED-10	84	2410	63	63	Vocalization
4392.PED-10	85	2410	64	64	Maternal/child relationship: mother's responsiveness
4393.PED-10	86	2410	65	65	Maternal/child relationship: mother's focus
4394.PED-10	87	2410	66	66	Maternal/child relationship: mother's attitude towards child
4395.PED-10	88	2410	67	67	Maternal/child relationship: child's appearance
4396.PED-10	89	2410	68	68	Neurological abnormalities
4397.PED-10	91	2410	69	69	Non-neurological abnormalities
4398.PED-10	92	2410	70	70	Examination conditions unsatisfactory
4399.PED-10	93	2410	71	71	Disposition for further evaluation
4400.PED-10	94	2410	72	72	Form CP-5 attached
4401.....		2410	73	80	Blank
4402.....		3410	1	5	Card number (sequence, form type, form number, revision number)
4403.....		3410	6	14	NINDB case number
4404.PED-10		3410	15	16	Age (rev 0)
4405.PED-10	6	3410	17	19	Temperature (rev 0)
4406.....		3410	20	20	Blank
4407.PED-10	34	3410	21	22	Eyes; pupil size, right (mm) (rev 0)
4408.PED-10	35	3410	23	24	Eyes; pupil size, left (mm) (rev 0)
4409.PED-10	36	3410	25	25	Eye reaction, right (rev 0)
4410.PED-10	37	3410	26	26	Eye reaction, left (rev 0)
4411.PED-10	40	3410	27	27	Arms; hands (rev 0)
4412.PED-10	41	3410	28	28	Legs; feet (rev 0)
4413.PED-10	47	3410	29	29	Movement; extremities, upper (rev 0)
4414.PED-10	47	3410	30	30	Movement; extremities, lower (rev 0)
4415.PED-10	49	3410	31	31	Neck (rev 0)
4416.PED-10	50	3410	32	32	Trunk (rev 0)
4417.PED-10	51	3410	33	33	Extremity, upper (rev 0)
4418.PED-10	52	3410	34	34	Extremity, lower (rev 0)
4419.PED-10	53	3410	35	35	Suck (rev 0)
4420.PED-10	67	3410	36	36	Movement; head, right, jaw arm (rev 0)
4421.PED-10	67	3410	37	37	Movement; head, right, jaw leg (rev 0)
4422.PED-10	67	3410	38	38	Movement; head, right, occiput arm (rev 0)
4423.PED-10	67	3410	39	39	Movement; head, right, occiput leg (rev 0)
4424.PED-10	67	3410	40	40	Movement; head, right, pelvic rotation (rev 0)

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4425.PED-10	6A	3410	41	41	Movement: head, left low arm (rev 0)
4426.PED-10	6A	3410	42	42	Movement: head, left low leg (rev 0)
4427.PED-10	6A	3410	43	43	Movement: head, left occiput arm (rev 0)
4428.PED-10	6A	3410	44	44	Movement: head, left occiput leg (rev 0)
4429.PED-10	6A	3410	45	45	Movement: head, left pelvic rotation (rev 0)
4430.PED-10	7S	3410	46	46	Response (rev 0)
4431.PED-10	7J	3410	47	47	Word response, arms (rev 0)
4432.PED-10	7K	3410	48	48	Word response, legs (rev 0)
4433.PED-10	7Q	3410	49	49	Word response, now obtained (rev 0)
4434.PED-10	H1	3410	50	50	Visual response (rev 0)
4435.PED-10	H2	3410	51	51	Diagnosis: abnormal (rev 0)
4436.PED-10	H2	3410	52	52	Diagnosis: malformation: congenital (rev 0)
4437.PED-10	H2	3410	53	53	Diagnosis: development, abnormal (rev 0)
4438.PED-10	H2	3410	54	54	Diagnosis: injury (rev 0)
4439.PED-10	H2	3410	55	55	Diagnosis: abnormality, other (rev 0)
4440.....		3410	56	80	Blank
5633....VAR			R07	R07	Pediatric exam present (4 mo)
5937....VAR	00		1124	1124	Neurological abnormalities, 4 months
5940....VAR	5		1127	1128	Age (wks)
5963....VAR	8		1162	1163	Head circumference, 4 mo (cms)
5964....VAR			1164	1164	Head circumference (coded)
5970....VAR	6		1177	1180	Weight, 4 mo (lbs/oz)
5978....VAR	7		1200	1201	Length: body, 4 mo (cms)
6178....VAR	6		1482	1486	Weight 4 mo (gms)

FOUR-MONTH PEDIATRIC EXAMINATION

2. NAME OF EXAMINER

3. STATUS

4. DATE OF EXAMINATION (Mo. Day Year) | 5. AGE (In mos.)

6. WEIGHT _____

7. BODY LENGTH

Total (Crown-heel) _____ cm.

Lower Segment (Soft-symphysis) _____ cm.

8. HEAD CIRCUMFERENCE _____ cm.

9. CHEST CIRCUMFERENCE _____ cm.

10. RESPIRATORY RATE (Baby at resting state) _____ per min.

11. HEART RATE (Baby at resting state) _____ per min.

12. SYSTOLIC BLOOD PRESSURE (Palpation) _____

13. SKIN

0 Normal (Including Mongolian Spots, Nevus Flammeus and Nevus Vascularis)

1 Pigmented Nevi

2 Vascular Nevi

3 Other Nevi

4 Loose and Dry Skin

5 Café au Lait Spots – approximate number _____

6 Other (Specify)

[42 items other than normal must be described]

14. SUBCUTANEOUS TISSUE

0 Normal

6 Other (Specify)

15. HAIR AND NAILS

0 Normal

6 Other (Specify)

16. HEAD

0 Normal

6 Other (Specify)

17. FONTANELLES

20. CLOSED _____ 21. OPEN

		SIZE	TENSION
18. ANT.	0	AP _____ Lat _____	0 Normal; 6 Other (Specify)
19. POST.	0	AP _____ Lat _____	0 Normal; 6 Other (Specify)

22. FACIES

0 Normal

1 Asymmetrical

6 Other (Specify)

23. MOVEMENTS OF FACE

0 Present and Symmetrical

1 Asymmetrical

8 Absent

6 Other (Specify)

24. COMMENTS

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

26. EYES

27. Right
- Normal
- Abnormal
  - Lid
  - Conjunctivae
  - Cornea
  - Pupil
  - Lens
  - Extraocular Muscles
  - Other (Specify)

28. Left
- Normal
- Abnormal
  - Lid
  - Conjunctivae
  - Cornea
  - Pupil
  - Lens
  - Extraocular Muscles
  - Other (Specify)

29. EARS

30. Right
- Normal
- Abnormal
  - Shape and Location
  - Canal
  - Drum
  - Other (Specify)

31. Left
- Normal
- Abnormal
  - Shape and Location
  - Canal
  - Drum
  - Other (Specify)

32. NOSE, MOUTH AND PHARYNX
- Normal
- Other (Specify)

33. NECK
- Normal
- Restricting Range of Motion
- Masses (Other than normal nodes)
- Other (Specify)

34. THORAX
- Normal
- Other (Specify)

35. RESPIRATORY
- Normal
- Other (Specify)

36. LUNGS
- Normal
- Other (Specify)

37. HEART
- Normal
- Irregular Rhythm
- Murmur (Describe)
- Rate
- Other (Specify)

38. FEMORAL PULSES
- Impalpable or Unequal Bilaterally
- Other (Specify)

39. COMMENTS

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

41. LYMPH NODES
- 1 Normal
- 2 Other (Specify)

42. ABDOMEN AND CONTENTS
- 1 Normal (including Umbilical Hernia)
- 2 Other (Specify)

43. LIVER
- 1 Normal
- 2 Other (Specify)

44. SPLEEN
- 1 Normal
- 2 Other (Specify)

45. KIDNEYS
- 1 Not Palpable
- 2 Palpable (Describe)

46. GENITALIA
- 1 Normal
- 2 Other (Specify)

47. ANAL SPHINCTER REFLEX
- 1 Normal
- 2 Other (Specify)

48. SPINE
- 1 Normal
- 2 Other (Specify)

49. MUSCULOSKELETAL SYSTEM

	Normal	Other (Specify)
50. Shoulder Girdle	1	2
51. Arms and Hands	1	2
52. Hands	1	2
53. Pelvic Girdle	1	2
54. Legs and Ankles	1	2
55. Feet	1	2

56. MOTOR ACTIVITY
- 1 Normal
- 2 Posturing or Jerky Movements
- 3 Rhythmical Jerky Movements
- 4 Athetoid Movements
- 5 Writhing Movements
- 6 Asymmetrical Movements
- 7 Paralysis
- 8 Local Convulsions
- 9 Generalized Convulsions
- 10 Other (Specify)

57. DO NOT WRITE IN THIS SPACE

58. COMMENTS

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

60. TONE – Use the following code which will indicate a gradation from flaccid to rigid. Describe on, necessary in right hand column.

1. Hypotonic
2. Questionable Hypotonicity
3. Normal
4. Questionable Hypertonicity
5. Hypertonic

	Bilateral	Right	Left
61. Upper Extremity			
62. Lower Extremity			
63. Neck Flexor			
64. Neck Extensor			
65. Trunk			

66. PALMAR GRASP
- [ ] a. Present
- [ ] c. Asymmetrical
- [ ] d. Absent

67. PLANTAR GRASP
- [ ] a. Present
- [ ] c. Asymmetrical
- [ ] d. Absent

68. PATELLAR JERK
- [ ] b. Present Bilaterally
- [ ] e. Other (Specify)

69. ANKLE JERK
- [ ] b. Present Bilaterally
- [ ] e. Other (Specify)

70. ANKLE CLONUS
- [ ] d. Absent Bilaterally
- [ ] e. Other (Specify)

71. HEARING RESPONSE
- [ ] a. Normal
- [ ] e. Other (Specify)

72. STEPPING (Child erect, sole of foot on surface, one knee and hand advanced forward)
- [ ] a. Present Bilaterally and Symmetrically
- [ ] b. Questionable Response (Describe)
- [ ] d. Absent Bilaterally
- [ ] c. Asymmetrical (Describe)
- [ ] c. Scissoring
- [ ] e. Other (Describe)

73. PLACING (Child held erect and dorsum of foot drawn under lower edge of surface)
- [ ] a. Present Bilaterally and Symmetrically
- [ ] b. Questionable Response (Describe)
- [ ] d. Absent Bilaterally
- [ ] c. Asymmetrical (Describe)
- [ ] e. Other (Describe)

74. RESPONSE TO IMAGE IN MIRROR (Check highest level of response)
- [ ] b. Smiles, Vocalizes or Pats Mirror
- [ ] c. Shows Interest in Image (Other than above)
- [ ] d. No Response to Image

75. COMMENTS

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

77. RESPONSE TO RED RING *(Check highest level of development)*

- 1 Plays With Ring
- 2 Grasps Ring
- 3 Follows Ring With Eyes
- 4 Reaches For Ring
- 0 None of Above

78. MOTOR SKILLS

	Yes	No	Unknown
Supports Some Weight On Feet	1	2	9
Prone — Supports On Forearms	1	2	9

79. SITTING WITH SUPPORT *(Check position of maximum response)*

	Yes	No
Head Erect and Steady	1	2
Head Erect or Slight Unsteadiness	1	2

80. PREDOMINANT POSITION OF HANDS

- 1 Open
- 2 Closed With Thumb In Fist
- 3 Closed With Thumb Out of Fist
- 0 Asymmetrical (Describe)

81. CRY

- 1 Normal
- 2 Absent
- 0 Other *(Specify)*

82. VOCALIZATION *(Check highest level of development)*

- 3 Coos or Laughs
- 2 Other Sounds Only
- 1 No Sounds

83. M. C. EVALUATION *(See Manual)*

84. Responsiveness to Child's Physical Needs

Unresp.		Resp.	Abn.		N/E
1	2	3	4	5	6

85. Mother's Focus of Attention During Examination

Child		Self	St.		N/E
1	2	3	4	5	6

86. Attitude Toward Child's Test Performance

Indif.		Int.	Dist.		N/E
1	2	3	4	5	6

87. Child's Appearance

P.C.F.		Approp.	Dist.		N/E
1	2	3	4	5	6

88. COMMENTS

[redacted]

[redacted]

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

IMPRESSION

90. NEUROLOGICAL ABNORMALITIES
- ☐ None
- ☐ Neurologically Suspicious But No Definite Abnormalities *(Describe reasons for this statement in detail)*
- ☐ Neurologically Abnormal Child *(Describe fully and give reasons)*

91. NON-NEUROLOGICAL ABNORMALITIES *(Check all that apply)*
- ☐ None
- ☐ Minor Abnormalities or Deviations *(Describe)*
- ☐ Questionable Abnormalities *(Describe)*
- ☐ Definite Major Abnormalities *(Describe)*

92. UNSATISFACTORY CONDITIONS FOR EXAMINATION
- ☐ Absent ☐ Present *(Specify)*

93. DISPOSITION
- ☐ No Indication For Further Evaluation At This Time
- ☐ Further Evaluation ... Or Scheduled *(Specify)*

94. CP-5 ATTACHED
- ☐ No ☐ Yes

95. MEDICAL EDITOR'S COMMENTS

96. COMMENTS

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[redacted]

Form Item Numbers linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4404.PED-10	3410	15	16	Age (rev 0)
	5064....VAR		1164	1164	Head circumference (coded)
	4341.PED-10	1410	79	80	Length, upper segment (cm)
	5631....VAR		807	807	Pediatric exam present (4 mo)
1	4304.PED-10	1410	25	26	Birth date (day)
1	4303.PED-10	1410	23	24	Birth date (mo)
1	4305.PED-10	1410	27	28	Birth date (yr)
4	4301.PED-10	1410	19	20	Form PED-10 date (day)
4	4300.PED-10	1410	17	18	Form PED-10 date (mo)
4	4302.PED-10	1410	21	22	Form PED-10 date (yr)
5	4299.PED-10	1410	15	16	Age (wks)
5	4344.PED-10	2410	15	16	Age (wks)
5	5960....VAR		1127	1128	Age (wks)
6	4405.PED-10	3410	17	19	Temperature (rev 0)
6	4306.PED-10	1410	29	30	Weight (lbs)
6	4307.PED-10	1410	31	32	Weight (oz)
6	6178....VAR		1482	1486	Weight 4 mo (gms)
6	5970....VAR		1177	1180	Weight, 4 mo (lbs/oz)
7	4309.PED-10	1410	35	36	Length, lower segment (cm)
7	4308.PED-10	1410	33	34	Length; body (cm)
7	5978....VAR		1200	1201	Length; body, 4 mo (cms)
8	4310.PED-10	1410	37	38	Head circumference (cm)
8	5963....VAR		1162	1163	Head circumference, 4 mo (cms)
9	4311.PED-10	1410	39	40	Chest circumference (cm)
10	4312.PED-10	1410	41	42	Respiratory rate
11	4313.PED-10	1410	43	45	Heart rate
12	4314.PED-10	1410	46	48	Blood pressure, systolic
13	4315.PED-10	1410	49	49	Skin appearance
14	4316.PED-10	1410	50	50	Subcutaneous tissue
15	4317.PED-10	1410	51	51	Hair; nails
16	4318.PED-10	1410	52	52	Head appearance
18	4320.PED-10	1410	54	55	Fontanelles, anterior, A-P size (cm)
18	4319.PED-10	1410	53	53	Fontanelles, anterior, condition
18	4321.PED-10	1410	56	57	Fontanelles, anterior, lateral (cm)
18	4322.PED-10	1410	58	58	Fontanelles, anterior, tension (cm)
19	4324.PED-10	1410	60	61	Fontanelles, posterior, A-P size (cm)
19	4323.PED-10	1410	59	59	Fontanelles, posterior, condition
19	4325.PED-10	1410	62	63	Fontanelles, posterior, lateral (cm)
19	4326.PED-10	1410	64	64	Fontanelles, posterior, tension (cm)
22	4327.PED-10	1410	65	65	Facies
23	4328.PED-10	1410	66	66	Movements: face
27	4329.PED-10	1410	67	67	Eye, right

Form Item Numbers linked to Data Items on PED-10, 6-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
28	4330.PED-10	1410	68	68	Eye, left
30	4331.PED-10	1410	69	69	Ear, right
31	4332.PED-10	1410	70	70	Ear, left
32	4333.PED-10	1410	71	71	Nose; mouth; pharynx
33	4334.PED-10	1410	72	72	Neck
34	4407.PED-10	3410	21	22	Eyes; pupil size, right (mm) (rev 0)
34	4335.PED-10	1410	73	73	Thorax
35	4408.PED-10	3410	23	24	Eyes; pupil size, left (mm) (rev 0)
35	4336.PED-10	1410	74	74	Respirations
36	4409.PED-10	3410	25	25	Eye reaction, right (rev 0)
36	4337.PED-10	1410	75	75	Lungs
37	4410.PED-10	3410	26	26	Eye reaction, left (rev 0)
37	4338.PED-10	1410	76	76	Heart
38	4339.PED-10	1410	77	77	Pulses; femoral
40	4411.PED-10	3410	27	27	Arms; hands (rev 0)
41	4412.PED-10	3410	28	28	Legs; feet (rev 0)
41	4345.PED-10	2410	17	17	Lymph; nodes
42	4346.PED-10	2410	18	18	Abdomen and contents
43	4347.PED-10	2410	19	19	Liver
44	4348.PED-10	2410	20	20	Spleen
45	4349.PED-10	2410	21	21	Kidneys
46	4350.PED-10	2410	22	22	Genitalia
47	4414.PED-10	3410	30	30	Movement; extremities, lower (rev 0)
47	4413.PED-10	3410	29	29	Movement; extremities, upper (rev 0)
47	4351.PED-10	2410	23	23	Reflex; anal sphincter
48	4352.PED-10	2410	24	24	Spine
49	4415.PED-10	3410	31	31	Neck (rev 0)
50	4353.PED-10	2410	25	25	Musculoskeletal; shoulder girdle
50	4416.PED-10	3410	32	32	Trunk (rev 0)
51	4417.PED-10	3410	33	33	Extremity, upper (rev 0)
51	4354.PED-10	2410	26	26	Musculoskeletal; arms; wrists
52	4418.PED-10	3410	34	34	Extremity, lower (rev 0)
52	4355.PED-10	2410	27	27	Musculoskeletal; hands
53	4356.PED-10	2410	28	28	Musculoskeletal; pelvic girdle
53	4419.PED-10	3410	35	35	Suck (rev 0)
54	4357.PED-10	2410	29	29	Musculoskeletal; legs; ankles
55	4358.PED-10	2410	30	30	Musculoskeletal; feet
56	4359.PED-10	2410	31	31	Motor activity
61	4360.PED-10	2410	32	32	Tone; extremity, upper, bilateral
61	4362.PED-10	2410	34	34	Tone; extremity, upper, left
61	4361.PED-10	2410	33	33	Tone; extremity, upper, right
62	4363.PED-10	2410	35	35	Tone; extremity, lower, bilateral
62	4365.PED-10	2410	37	37	Tone; extremity, lower, left

Form Item Numbers linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
62	4364.PED-10	2410	36	36	Tone: extremity, lower, right
63	4366.PED-10	2410	38	38	Tone: neck flexor, bilateral
63	4368.PED-10	2410	40	40	Tone: neck flexor, left
63	4367.PED-10	2410	39	39	Tone: neck flexor, right
64	4369.PED-10	2410	41	41	Tone: neck extensor, bilateral
64	4371.PED-10	2410	43	43	Tone: neck extensor, left
64	4370.PED-10	2410	42	42	Tone: neck extensor, right
65	4372.PED-10	2410	44	44	Tone: trunk, bilateral
65	4374.PED-10	2410	46	46	Tone: trunk, left
65	4373.PED-10	2410	45	45	Tone: trunk, right
66	4375.PED-10	2410	47	47	Grasp: palmar
67	4376.PED-10	2410	48	48	Grasp: plantar
67	4420.PED-10	3410	36	36	Movement: head, right, jaw arm (rev 0)
67	4421.PED-10	3410	37	37	Movement: head, right, jaw leg (rev 0)
67	4422.PED-10	3410	38	38	Movement: head, right, occiput arm (rev 0)
67	4423.PED-10	3410	39	39	Movement: head, right, occiput leg (rev 0)
67	4424.PED-10	3410	40	40	Movement: head, right, pelvic rotation (rev 0)
68	4425.PED-10	3410	41	41	Movement: head, left jaw arm (rev 0)
68	4426.PED-10	3410	42	42	Movement: head, left jaw leg (rev 0)
68	4427.PED-10	3410	43	43	Movement: head, left occiput arm (rev 0)
68	4428.PED-10	3410	44	44	Movement: head, left occiput leg (rev 0)
68	4429.PED-10	3410	45	45	Movement: head, left pelvic rotation (rev 0)
68	4377.PED-10	3410	49	49	Reflex: patellar jerk
69	4378.PED-10	2410	50	50	Reflex: ankle jerk
70	4379.PED-10	2410	51	51	Clonus: ankle
71	4380.PED-10	2410	52	52	Hearing response
72	4381.PED-10	2410	53	53	Stepping response
73	4382.PED-10	2410	54	54	Placing response
74	4383.PED-10	2410	55	55	Response to mirror image
75	4430.PED-10	3410	46	46	Response (rev 0)
77	4431.PED-10	3410	47	47	Moro response, arms (rev 0)
77	4384.PED-10	2410	56	56	Response to red ring
78	4432.PED-10	3410	48	48	Moro response, legs (rev 0)
78	4386.PED-10	2410	58	58	Motor skills, prone
78	4385.PED-10	2410	57	57	Motor skills, supports weight
79	4433.PED-10	3410	49	49	Moro response, how obtained (rev 0)
79	4387.PED-10	2410	59	59	Motor skills, sitting head erect
79	4388.PED-10	2410	60	60	Motor skills, sitting spine erect
80	4389.PED-10	2410	61	61	Hands, predominant position
81	4390.PED-10	2410	62	62	Cry
81	4434.PED-10	3410	50	50	Visual response (rev 0)
82	4435.PED-10	3410	51	51	Diagnosis: abnormal (rev 0)
82	4439.PED-10	3410	55	55	Diagnosis: abnormality, other (rev 0)

Form Item Numbers linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
82	4437.PED-10	3410	53	53	Diagnosis: development, abnormal (rev 0)
82	4438.PED-10	3410	54	54	Diagnosis: injury (rev 0)
82	4436.PED-10	3410	52	52	Diagnosis: malformation: congenital (rev 0)
82	4391.PED-10	2410	63	63	Vocalization
84	4392.PED-10	2410	64	64	Maternal/child relationship: mother's responsiveness
85	4393.PED-10	2410	65	65	Maternal/child relationship: mother's focus
86	4394.PED-10	2410	66	66	Maternal/child relationship: mother's attitude towards child
87	4395.PED-10	2410	67	67	Maternal/child relationship: child's appearance
90	4396.PED-10	2410	68	68	Neurological abnormalities
90	5937....VAR		1124	1124	Neurological abnormalities, 4 months
91	4397.PED-10	2410	69	69	Non-neurological abnormalities
92	4398.PED-10	2410	70	70	Examination conditions unsatisfactory
93	4399.PED-10	2410	71	71	Disposition for further evaluation
94	4400.PED-10	2410	72	72	Form CY-5 attached

DEFINITION OF CODES
FOUR MONTH PEDIATRIC EXAMINATION
FORM PED-10 CARD 1410

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 410	2-4
3.	Revision Number * Code: 0 - Form Dated: Undated 1 - Form Dated: Rev. 10/60	5
4.	NIMDB # Item 1 Nine-digit number for Patient Identification	6-14
5.	Age Item 5 Code: As given 98 - 98 weeks or more	15-16
6.	Date of Examination Item 4 Six-digit code for month (cols. 17-18), day (cols. 19-20) and year (cols. 21-22) Code: As given	17-22
7.	Date of Birth Item 1 Code: Same as in Field 6	23-28
8.	Weight Item 6 Code: 0500-2515 - As given in pounds and ounces 9999 - Not reported	29-32

* Unless specified Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: Rev. 10/60.

FIELD		CARD COLUMN
9.	**Body Length - Total** Item 7 Code: 25-75 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 76-78, 80	33-34
10.	**Body Length - Lower Segment** Item 7 Code: 12-45 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 65	35-36
11.	**Head Circumference** Item 8 Code: 30-48 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 27,49, 50, 53, 60	37-38
12.	**Chest Circumference** Item 9 Code: 30-50 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 26-28, 29, 51	39-40
13.	**Respiratory Rate** Item 10 Code: 10-97 - As given in cms. 98 - 98 or more 99 - Not reported	41-42
14.	**Heart Rate** Item 11 Code: 050-200 - As given 999 - Not reported Additional codes reviewed and approved : 040, 204, 205, 210, 216, 220, 224	43-45
15.	**Systolic Blood Pressure** Item 12 Code: 040-200 - As given 999 - Not reported Additional codes reviewed and approved: 030, 032, 035, 036, 038, 039, 230	46-48

FIELD		CARD COLUMN
16.	**Skin** Item 13. Code: 0 - Normal 1 - Pigmented nevi (Revision "1" only) 2 - Vascular nevi (Revision "1" only) 3 - Other rashes (Revision "1" only) 4 - Loose and wrinkled (Revision "1" only) 5 - Cafe au lait spots (Revision "1" only) 7 - Combination of codes (Revision "1" only) 8 - Other 9 - Not reported	49
17.	**Subcutaneous Tissue**(Revision "1" only) Item 14. Code: Blank - Not on Revision "0" 0 - Normal 8 - Other 9 - Not reported	50
18.	**Hair and Nails** (Revision "1" only) Item 15 Code: Blank - Not on Revision "0" 0 - Normal 8 - Other 9 - Not reported	51
19.	**Head** Item 16. Code: 0 - Normal 8 - Other 9 - Not reported	52

DEFINITION OF CODES (Continued)

FORM PED-10
Card 1410

FIELD		CARD COLUMN
20.	**Anterior Fontanelles** Item 18 Code: 0 - Closed 1 - Open 9 - Not reported	53
21.	**Anterior Fontanelles - AP Size** Item 18 Code: X and blank - Closed or not reported in Field 20 (Rev. "1" only) 00 - Less than one cm. 01-08 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 09-12, 15	54-55
22.	**Anterior Fontanelles - Lat. Size** Item 18 Code: Same as in Field 21 except that Blank = Closed or not reported in Field 20 (Rev. "1" only) Additional codes reviewed and approved: 09, 10, 12	56-57
23.	**Anterior Fontanelles - Tension** (Rev. "1" only) Item 18 Code: Blank - Closed or not reported in Field 20 for Rev. "1" only, not on Rev. "0" 0 - Tension 8 - Other 9 - Not reported	58
24.	**Posterior Fontanelles** Item 19 Code: Same as in Field 20	59
25.	**Posterior Fontanelles - AP Size** Item 19 Code: Same as in Field 21 except that numeric (-) and blank = Closed or not reported in Field 24 (Rev. "1" only) Additional codes reviewed and approved: 09	60-61
26.	**Posterior Fontanelles - Lat. Size** Item 19 Code: Same as in Field 21 except that Blank = Closed or not reported in Field 24 (Rev. "1" only)	62-63

FIELD		CARD COLUMN
27.	Posterior Fontanelles - Tension (Revision "1" only) Item 19 Code: Blank - Closed or not reported in Field 24, not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	64
28.	Facies (Revision "1" only) Item 22 Code: Blank - Not on Rev. "0" 0 - Normal 1 - Asymmetrical 8 - Other 9 - Not reported	65
29.	Movements of Face Item 23 Code: 0 - Present and symmetrical 1 - Asymmetrical 2 - Absent 8 - Other 9 - Not reported	66
30.	Right Eye Item 27 Code: 0 - Normal 1 - Lid abnormal (Rev. "1" only) 2 - Conjunctiva (Rev. "1" only) 3 - Cornea 4 - Pupil 5 - Lens 6 - Extraocular muscles(Rev. "1" only) 7 - Combination of codes 8 - Other 9 - Not reported	67
31.	Left Eye Item 28 Code: Same as in Field 30	68

DEFINITION OF CODES (Continued)

FORM PED-10
Card 2&10

FIELD		CARD COLUMN
32.	Right Ear Item 30 Code: 0 - Normal 1 - Shape and Location 2 - Canal 3 - Drum 7 - Combination of codes 8 - Other 9 - Not reported	69
33.	Left Ear Item 31 Code: Same as in Field 32	70
34.	Nose, Mouth and Pharynx Item 32 Code: 0 - Normal 8 - Other 9 - Not reported	71
35.	Neck Item 33 Code: 0 - Normal 1 - Restricted range of motion 2 - Masses 7 - Combination of codes (Rev. "1" only) 8 - Other 9 - Not reported	72
36.	Thorax (Revision "1" only) Item 34 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	73
37.	Respirations Item 35 Code: 0 - Normal 8 - Other 9 - Not reported	74

FIELD		CARD COLUMN
38.	**Lungs** Item 36 Code: Same as in Field 37	75
39.	**Heart** Item 37 Code: 0 - Normal 1 - Irregular rhythm 2 - Murmur 3 - Thrill 7 - Combination of codes 8 - Other 9 - No report	76
40.	**Femoral Pulses** (Revision "1" only) Item 38 Code: Blank - Not on Rev. "0" 0 - Strong and equal bilaterally 8 - Other 9 - Not reported	77
41.	Blank	78
42.	**Length - Upper Segment** (Rev. "0" only) Two-digit code for centimeters Code: 00 - Less than one cm. 01-97 - As given in cms. 98 - 98 and over 99 - Not reported Blank - not on Rev. 1	79-80

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1	2-16
3.	Lymph Nodes (Revision "1" only) Item 41 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	17
4.	Abdomen and Contents Item 42 Code: 0 - Normal 8 - Other 9 - Not reported	18
5.	Liver Item 43 Code: 0 - Normal 8 - Other 9 - Not reported	19
6.	Spleen Item 44 Code: 0 - Normal 8 - Other 9 - Not reported	20

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Form Dated: Rev. 10/60.

FIELD		CARD COLUMN
7.	Kidneys Item 45 Code: 0 - Not palpable 1 - Palpable 9 - Not reported	21
8.	Genitalia Item 46 Code: 0 - Normal 8 - Other 9 - Not reported	22
9.	Anal Sphincter Reflex (Revision "1" only) Item 47 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	23
10.	Spine Item 48 Code: 0 - Normal 8 - Other 9 - Not reported	24
11.	Shoulder Girdle (Revision "1" only) Item 50 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	25
12.	Arms and Wrists (Revision "1" only Item 51 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	26

FIELD		CARD COLUMN
13.	**Hands** (Revision "1" only) Item 52 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	27
14.	**Pelvic Girdle** (Revision "1" only) Item 53 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	28
15.	**Legs and Ankles** (Revision "1" only) Item 54 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	29
16.	**Feet** (Revision "1" only) Item 55 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	30
17.	**Motor Activity** Item 56 Code: 0 - Normal 1 - Tremulous or jittery movements 2 - Jerky or myoclonic movements 3 - Writhing movements 4 - Asymmetrical movements (Revision "1" only) 5 - Local convulsions 6 - Generalized convulsions 7 - Combination of codes (Revision "1" only) 8 - Other (Paralysis) 9 - Not reported	31

FIELD		CARD COLUMN
18.	Tone: Upper Extremity (Rev. "1" only) Item 61 Three-digit code for: Bilateral (col. 32) Right (col. 33) Left (col. 34) Code for each column: Blank - Not on Rev. "0" 0 - Not applicable 1 - Hypotonic 2 - Questionable hypotonicity 3 - Normal 4 - Questionable hypertonicity 5 - Hypertonic 9 - Not reported	32-34
19.	Tone: Lower Extremity (Rev. "1" only) Item 62 Code: Same as in Field 18	35-37
20.	Tone: Neck Flexor (Rev. "1" only) Item 63 Code: Same as in Field 18	38-40
21.	Tone: Neck Extensor (Rev. "1" only) Item 64 Code: Same as in Field 18	41-43
22.	Tone: Trunk (Rev. "1" only) Item 65 Code: Same as in Field 18	44-46
23.	Palmar Grasp Item 66 Code: 0 - Present 1 - Asymmetrical 2 - Absent 9 - Not reported	47

FIELD		CARD COLUMN
24.	Plantar Grasp (Revision "1" only) Item 67 Code: Blank - Not on Rev. "0" 0 - Present 1 - Asymmetrical 2 - Absent 9 - Not reported	48
25.	Patellar Jerk Item 68 Code: 0 - Present bilaterally 8 - Other 9 - Not reported	49
26.	Ankle Jerk Item 69 Code: 0 - Present bilaterally 8 - Other 9 - Not reported	50
27.	Ankle Clonus Item 70 Code: 0 - Absent bilaterally 8 - Other 9 - Not reported	51
28.	Hearing Response Item 71 Code: 0 - Normal 8 - Other 9 - Not reported	52

FIELD		CARD COLUMN
29.	**Stepping** (Revision "1" only) Item 72 Code: Blank - Not on Rev. "0" 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 4 - Scissoring 8 - Other 9 - Not reported	53
30.	**Placing** (Revision "1" only) Item 73 Code: Blank - Not on Rev. "0" 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 8 - Other 9 - Not reported	54
31.	**Response to Image in Mirror** (Revision "1" only) Item 74 Code: Blank - Not on Rev. "0" 1 - Smiles, vocalizes or pats mirror 2 - Shows interest in mirror 8 - No response to image 9 - Not reported	55
32.	**Response to Red Ring** (Revision "1" only) Item 77 Code: Blank - Not on Rev. "0" 1 - Plays with ring 2 - Grasps ring 3 - Follows ring with eyes 4 - Regards red ring 8 - None of above 9 - No report	56

FIELD		CARD COLUMN
33.	Motor Skills: Supports Weight (Revision "1" only) Item 78 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Unknown	57
34.	Motor Skills: Prone (Rev. "1" only) Item 78 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Unknown	58
35.	Sitting With Support: Head Erect (Revision "1" only) Item 79 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Not reported	59
36.	Sitting With Support: Spine Erect (Revision "1" only) Item 79 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Not reported	60
37.	Predominant Position of Hands (Revision "1" only) Item 80 Code: Blank - Not on Rev. "0" 1 - Open 2 - Closed with thumb in fist 3 - Closed with thumb out of fist 4 - Asymmetrical 9 - Not reported	61

FIELD		CARD COLUMN
38.	Cry (Revision "1" only) Item 81 Code: Blank - Not on Rev. "0" 0 - Normal 1 - Absent 8 - Other 9 - Not reported	62
39.	Vocalization (Revision "1" only) Item 82 Code: Blank - Not on Rev. "0" 1 - Coos or laughs 2 - Other sounds only 3 - No sounds 9 - Not reported	63
40.	Evaluation: Mother's Responsiveness (Revision "1" only) Item 84 Code: Blank - Not on Rev. "0" 1 - Unaware and unresponsive 2 - Slow in responding 3 - Appropriate recognition 4 - Overprotective in moderation 5 - Extremely absorbed 9 - Unknown	64
41.	Evaluation: Mother's Focus (Rev. "1" only) Item 85 Code: Blank - Not on Rev. "0" 1 - All attention on child 2 - Tried to involve herself 3 - Appropriate attention 4 - Occasionally interrupted 5 - Demanded all attention 9 - Unknown	65
42.	Evaluation: Attitude Towards Child (Revision "1" only) Item 86 Code: Blank - Not on Rev. "0" 1 - Completely indifferent 2 - Brief and fleeting interest 3 - Intermediate	66

FIELD		CARD COLUMN
42.	Evaluation: Attitude Towards Child (Continued) Code: 4 - Excessive pride in successes, and minimized failures 5 - Overly absorbed in performance 9 - Unknown	66
43.	Evaluation: Child's Appearance (Revision "1" only) Item 87 Code: Blank - Not on Rev. "0" 1 - Poorly cared for 2 - Moderately poorly cared for 3 - Appropriate care and attention 4 - Moderately overdone 5 - Overdone to extreme 9 - Unknown	67
44.	Neurological Abnormalities (Rev. "1" only) Item 90 Code: Blank - Not on Rev. "0" 0 - None 1 - Suspicious 2 - Definite 9 - Not reported	68
45.	Non-Neurological Abnormalities (Rev. "1" only) Item 91 Code: Blank - Not on Rev. "0" 0 - None 1 - Minor 2 - Questionable 3 - Definite 7 - Combination of codes 9 - Not reported	69
46.	Unsatisfactory Conditions for Examination (Rev. "1" only) Item 92 Code: Blank - Not on Rev. "0" 0 - Absent 1 - Present 9 - Not reported	70

DEFINITION OF CODES (Continued)

FORM PED-1C
CARD 2&10

FIELD		CARD COLUMN
47.	Disposition (Revision "1" only) Item 93 Code: Blank - Not on Rev. "0" 0 - No indication for further evaluation 8 - Further evaluation 9 - Not reported	71
48.	CP-5 Attached (Revision "1" only) Item 94 Code: Blank - Not on Rev. "0" 0 - Not attached 1 - Attached 9 - Not reported	72

NOTE: This card should not be used in Tabulations.

FIELD		CARD COLUMN
1.	Card Number Code: 3	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1, except column 5 is Rev. "0" only	2-16
3.	Body Temperature Item 6 Code: 093-107 - As given 999 - Not reported	17-19
4.	Chest Item 12 Code: 0 - Symmetrical 1 - Asymmetrical 9 - Not reported	20
5.	Right Pupil - Size Item 34 Code: As given in mm. 99 - Not reported	21-22
6.	Left Eye - Size Item 35 Code: Same as in Field 5	23-24
7.	Right Eye - Reaction Item 36 Code: 0 - Present 1 - Absent 9 - Not reported	25

* Fields, Codes, Item Numbers and Card Columns refer to Revision "0" only.

DEFINITION OF CODES (Continued)

FORM PED-1C
CARD 3410

FIELD		CARD COLUMN
8.	Left Eye - Reaction Item 37 Code: 0 - Present 1 - Absent 9 - Not reported	26
9.	Arms and Hands Item 40 Code: 0 - Normal 1 - Abnormal 9 - Not reported	27
10.	Legs and Feet Item 41 Code: 0 - Normal 1 - Abnormal 9 - Not reported	28
11.	Movement of Upper Extremities Item 46 Code: 0 - Normal 1 - Abnormal 9 - Not reported	29
12.	Movement of Lower Extremities Item 47 Code: 0 - Normal 1 - Abnormal 9 - Not reported	30
13.	Neck Item 49 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	31

FIELD		CARD COLUMN
14.	**Trunk** Item 50 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	32
15.	**Upper Extremity** Item 51 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	33
16.	**Lower Extremity** Item 52 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	34
17.	**Suck** Item 53 Code: 0 - Strong 1 - Weak 2 - Absent 9 - Not reported	35
18.	**Head Movement to Right** Item 67 Five-digit code for: Jaw Arm (col. 36) Jaw Leg (col. 37) Occiput Arm (col. 38) Occiput Leg (col. 39)	36-40

18. Head Movement to Right (continued) 36-40

Code for each column:
0 - Extension present
1 - Flexion present
2 - Extension and Flexion absent
8 - No pattern
9 - No report

Pelvic Rotation (col. 40)
Code:
0 - Rotation away from jaw
1 - Rotation toward jaw
2 - No rotation
8 - No constant pattern
9 - No report

19. Head Movement to Left 41-45
Item 58
Code: Same as in Field 18

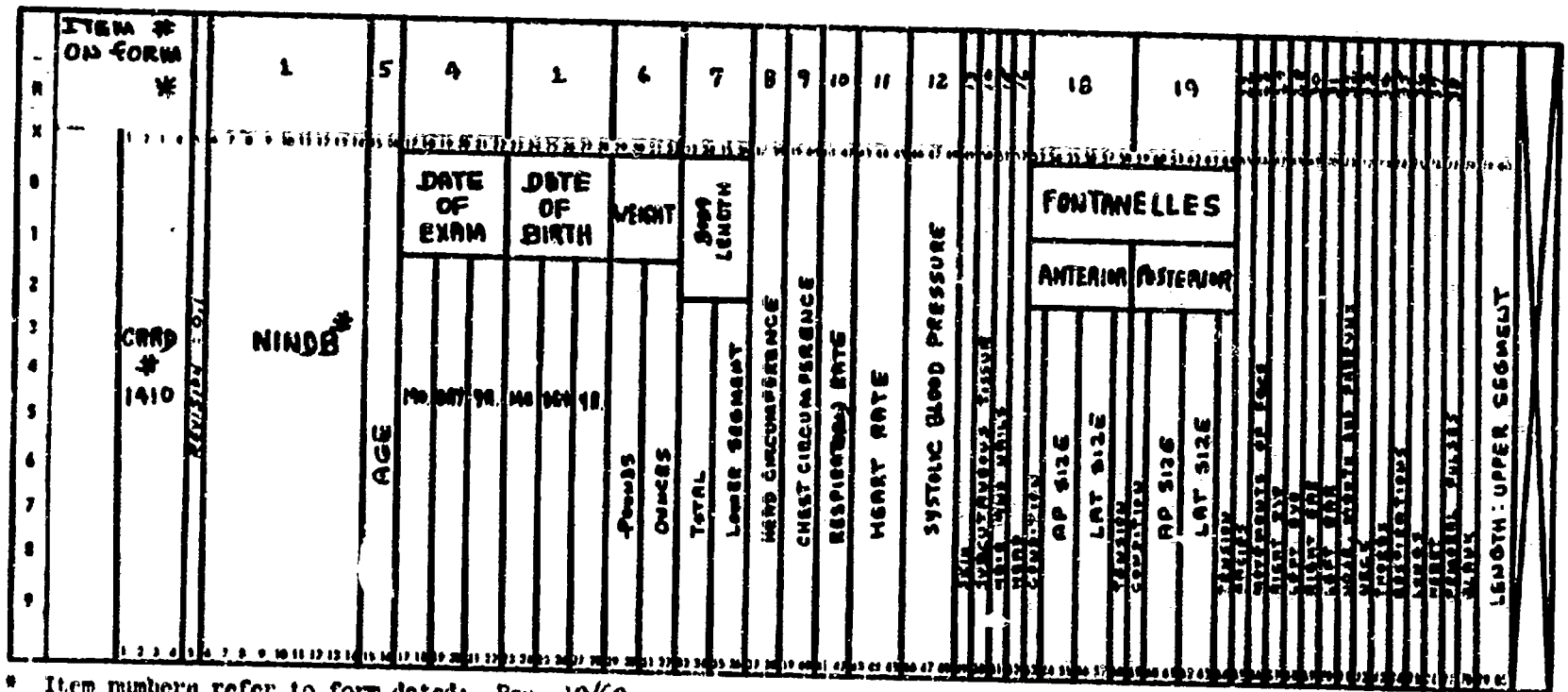
20. Response 46
Item 79
Code: 1 - Obtained with ease
2 - Obtained with difficulty
3 - No constant pattern
9 - Not reported

21. Moro: Response of Arms 47
Item 77
Code: 0 - Normal
1 - Flexor component absent
2 - Asymmetrical
3 - No constant pattern
4 - Absent
8 - Other
9 - Not reported

22. Moro: Response of Legs 48
Item 78
Code: 0 - Flexor
3 - No constant pattern
4 - Absent
8 - Other
9 - Not reported

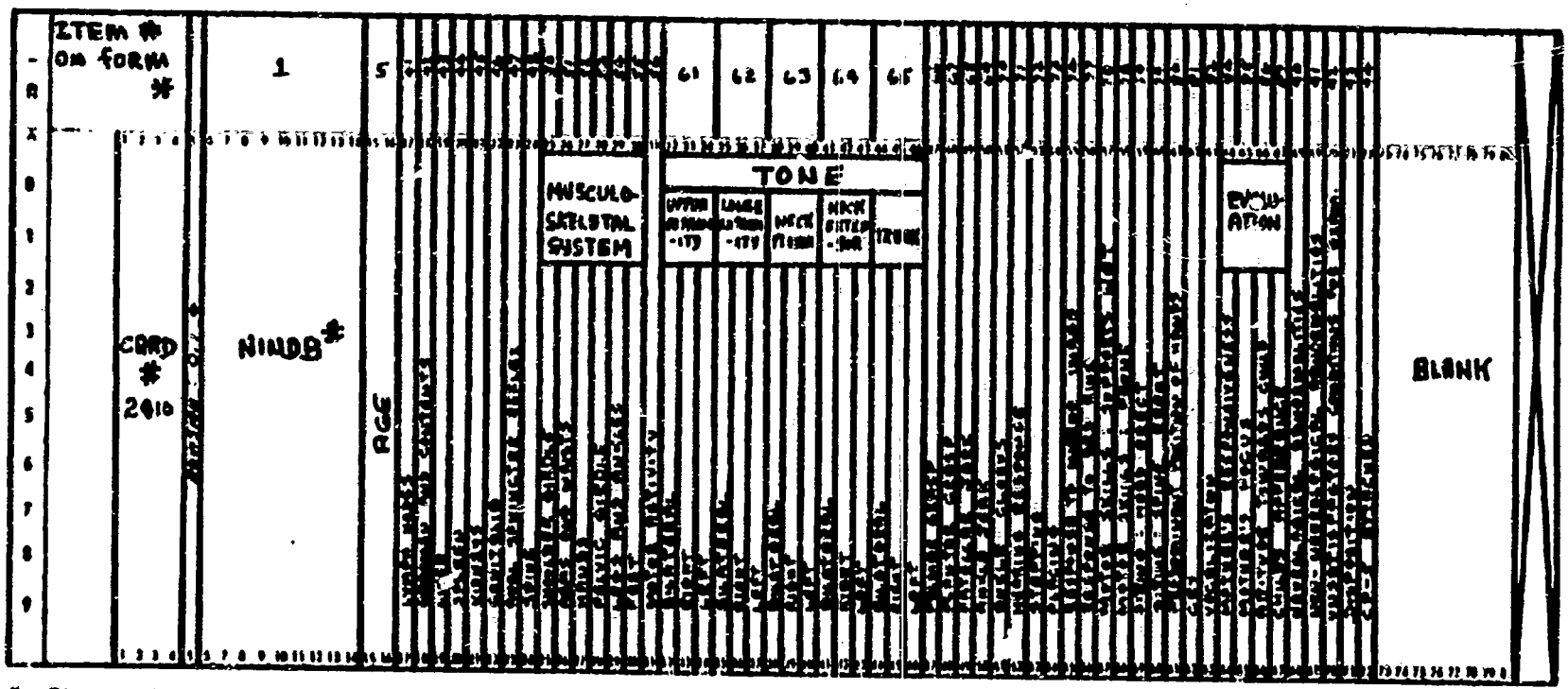
FIELD		CARD COLUMN
23.	**Moro: Response** Item 79 Code: 1 - Obtained with ease 2 - Obtained with difficulty 3 - No constant pattern 9 - Not reported	49
24.	**Visual Response** Item 81 Code: 0 - Present 1 - Absent 9 - Not reported	50
25.	**Diagnosis** Item 82 Five-digit code for: Abnormal (col. 51) Congenital Malformation (col. 52) Abnormal Development (col. 53) Injury (col. 54) Other Abnormality (col. 55) Code for each column: 0 - No 1 - Yes 9 - No report	51-55

FOUR-MONTH PEDIATRIC EXAMINATION
FORM FED-10



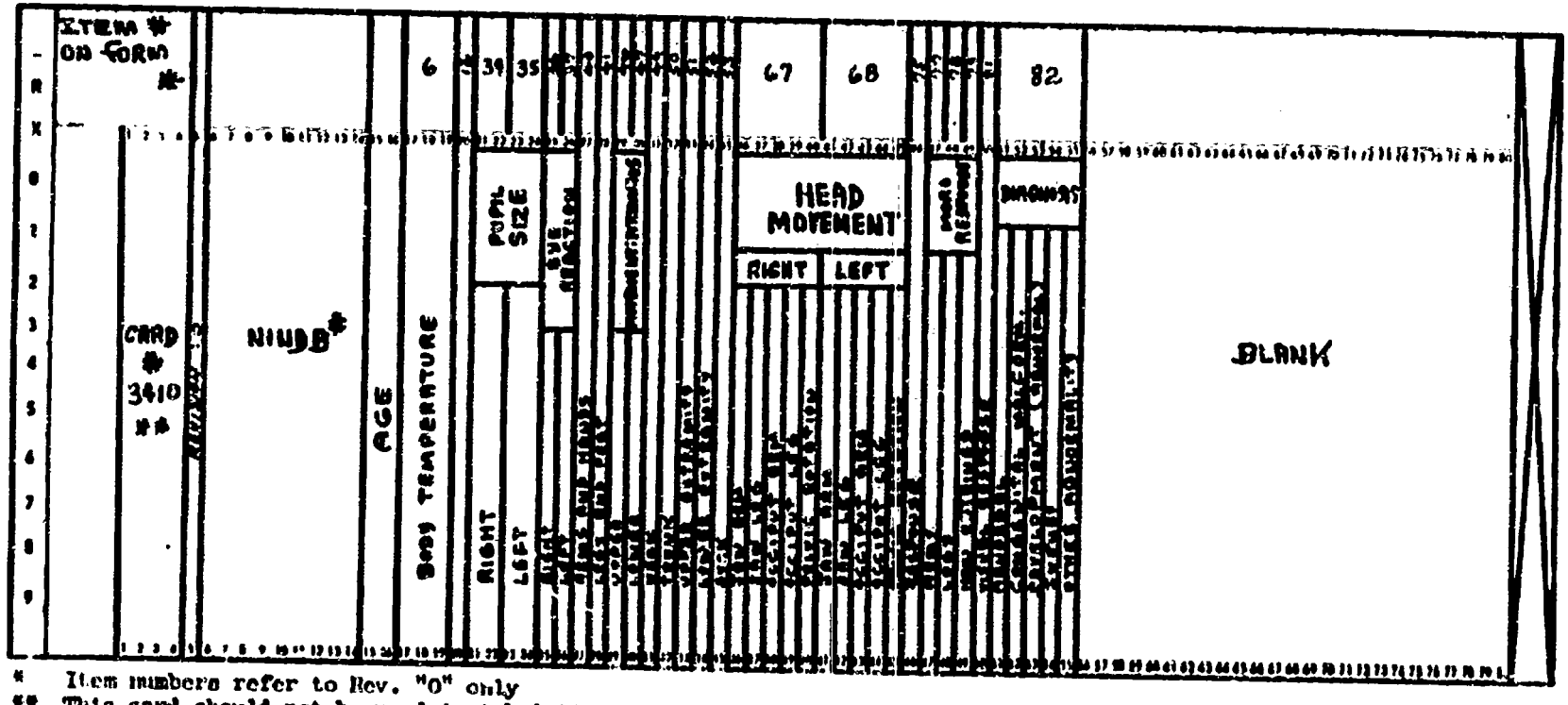
* Item numbers refer to form dated: Rev. 10/60

FOUR-MONTH PEDIATRIC EXAMINATION
FORM PED-10



* Item numbers refer to form dated: Rev. 10/60

FOUR-MONTH PEDIATRIC EXAMINATION
FORM PED-10



* Item numbers refer to Rev. "0" only
** This card should not be used in tabulations

PEDIATRICS MANUAL
4-Month Pediatric Examination
(For Form PED-10, Rev. 10-60)

I. INTRODUCTION

The purpose of the 4-Month Pediatric Examination is to detect evidences of injury or disease in the infant with particular emphasis on differentiating conditions related to the prenatal or perinatal period from those acquired in the postnatal period. Measurements and other pertinent observations are to be recorded as baseline information against which subsequent observations and measurements can be compared. The examination also includes a judgment of the child's status – normal or abnormal – and a judgment of the maternal-child relationship.

A form (PED-10) has been developed for the recording of information obtained in the 4-Month Pediatric Examination. This manual has been prepared for use as a guide to performing the examination and also to assist in the proper recording of the information obtained.

II. GENERAL INSTRUCTIONS

A. THE EXAMINER

A pediatrician should conduct the 4-Month Pediatric Examination. He may instruct a nurse to obtain measurements and vital signs.

B. TIMING OF EXAMINATION

The examination should be done between 14 and 20 weeks of age. If this is impossible every effort should be made to perform the examination as close as possible to the specified time.

C. ABNORMALITIES

When abnormalities are found, additional observations and tests as necessary to describe and elucidate the abnormality are expected to be performed. The examiner need not limit his description of abnormalities to conform to the limits of this examination. Additional tests or data about abnormalities should be recorded on an attached CP-5.

D. ELIMINATION OF BIAS

The examiner should not know the child's history or the findings of previous examinations prior to doing the examination.

The examiner should not be the person taking the 4-Month Interval History. However, once having completed the examination he should refer to the 4-Month Interval History and past physical examinations and all abnormal or suspicious findings should be rechecked. Such observations and correlations with histories, if made, should be recorded on an attached CP-5 and Item 94 checked.

E. RECORDING INSTRUCTIONS

All items on this form are to be completed. If unable to evaluate or properly record an item write NE (not evaluated) next to the item and explain in the right-hand column.

If checked other than normal, a description should accompany the item in the right-hand column. To insure identification of descriptions and comments each should bear the number of the item it concerns.

III. SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. Use the patient's name plate. This should contain at least the child's name, NINDB number, birth date, birth weight, race, and sex.

Item 2, Examiner's Name. Record surname and initials, or full name if necessary for positive identification.

Item 3, Examiner's Status. Record the examiner's status such as pediatrician, pediatric resident, etc.

Item 4, Date of Examination. Record the date using the sequence month, day and year.

Item 5, Age. Record the child's age as weeks completed.

Item 6, Weight. It is desirable that weight be recorded in metric units. However, if an English system scale is used, report weight in pounds and ounces rather than converting to grams.

Item 7, Body Length. The total body length (crown to heel) should be measured with the child in supine position using an "Infantometer" or other similar measuring device. The length of the lower segment (heel to symphysis) should be measured with a flexible measuring tape from

the heel to the upper portion of the symphysis. All measurements should be recorded in centimeters.

Item 8, Head Circumference. Head circumference is measured with a flexible tape applied firmly over supra-orbital ridges anteriorly and that part of the occiput posteriorly which gives the maximum circumference. Record in centimeters.

Item 9, Chest Circumference. The girth of the thorax is measured at the level of the nipples in a plane at right angles to the vertebral column. Attempt to measure at expiration. Record in centimeters.

Item 10, Respiratory Rate. Respirations are counted for at least 30 seconds with the child in a resting state. Record the rate as respirations per minute. If impossible to put the child in a resting state record as "NE" (not evaluated).

Item 11, Heart Rate. Count the heart beats for at least 30 seconds with the child in a resting state. Record the rate as beats per minute. If unable to put the child in a resting state record as "NE" (not evaluated).

Item 12, Systolic Blood Pressure. Determine systolic blood pressure in the upper part of the right arm using the palpation method. Approximately 2/3 of the upper arm should be covered with the blood pressure cuff. Determine blood pressure with the child in a resting state. If unable to put the child in a resting state record as "NE" (not evaluated).

Item 13, Skin. This calls for an observation of the color and texture of the skin as well as a search for specific lesions. "Stork bites," Mongolian spots, and diaper rash are to be considered normal findings and are not to be described. "Stork bites" are defined as those capillary clusters or nonelevated hemangiomas found frequently on the nape of the neck, bridge of the nose, or eyelids. Cafe au lait spots should be described as to size, shape and depth of pigment if their number is six or over. Rashes other than uncomplicated ammoniacal dermatitis should be recorded and described. All findings other than normal should be described in the right-hand column. Do not include pilonidal sinuses or dimples here but record instead under Item 48, "Spine."

Item 14, Subcutaneous Tissue. Evaluate by observation and palpation. Quantity, texture and distribution should be noted if other than normal.

Item 15, Hair and Nails. Observe the texture, quantity, distribution, color, etc., of the hair and the size, configuration and texture of the nails. Evaluate and describe unusual findings.

Item 16, Head. Evaluate the child's head noting especially the size and configuration. Include an evaluation of the sutures.

Items 17-21, Fontanelles. Evaluate the size and tension of fontanelles. If open, record the size of the fontanelle in centimeters giving both the antero-posterior and lateral measurements. Do not record size in fingertips or fingerbreadths. If either or both fontanelles are closed indicate by checking the appropriate box. If the box "Closed" is checked, no mark is necessary in the corresponding "Size" and "Tension" spaces.

Item 22, Facies. Evaluate expression, symmetry and structure. Unusual facies should be described. Muscle function should be reported in Item 23, Movements of Face.

Item 23, Movements of Face. This represents the examiner's observation of the spontaneous movements of the infant's face. The observation should not be a brief one. It should take place periodically throughout the examination. No judgment or recording of this item should be made until the examination is complete. No special stimuli should be used to bring out the facial movements; the stimuli of the examination procedures should be sufficient. "Present and symmetrical" is considered the normal response.

Item 24, Comments. Record comments or descriptions concerning the numbered items. Be careful to identify the comment with the number of the item it concerns.

Item 25, Patient Identification. Same as Item 1.

Items 26-28, Eyes. The lid, conjunctiva, cornea, pupil, lens and extraocular muscles should be evaluated. Report ptosis and strabismus under category 6, "Extraocular Muscles," and spontaneous nystagmus under category 8, "Other." Clearly identify abnormalities as "right," "left," or "bilateral."

Items 29-31, Ears. Evaluate the shape and location of the external ears as well as examining the canal and drum. Clearly identify abnormalities as "right," "left," or "bilateral." Interpret the phrase "Abnormal – Shape and Location"

as "Abnormal – Shape and or Location."

Item 32, Nose, Mouth and Pharynx. Look for discharge, specific lesions and malformations. Unusual dental findings should be described here.

Item 33, Neck. Evaluate by inspection, palpation and manipulation. Enlarged cervical nodes should be recorded under Item 41, Lymph Nodes.

Item 34, Thorax. Evaluate the thoracic cage. Do not include cardiorespiratory findings under this item; record under Items 35-37.

Item 35, Respirations. Evaluate the rhythm, symmetry and character of the respirations with the infant in as near a resting state as possible. Since rate is reported above do not use abnormal rate as the sole criterion in determining an abnormality under this item.

Item 36, Lungs. Evaluate by auscultation and percussion.

Item 37, Heart. Evaluate by palpation and auscultation. Murmurs should be described as to character, grade of intensity (use 4 point scale), point of maximal intensity, distribution, transmission and postural variation.

Item 38, Femoral Pulses. Determine by palpation the strength and symmetry of the femoral pulses.

Item 39, Comments. Same as Item 24.

Item 40, Patient Identification. Same as Item 1.

Item 41, Lymph Nodes. Palpate the major superficial lymph node areas and report any unusual findings.

Item 42, Abdomen and Contents. Evaluate the abdominal wall and contents by inspection, palpation and percussion. Report here masses, distension, marked diastasis recti, inguinal and femoral hernias, and complicated umbilical hernias, fluid, etc. Do not record findings of the liver, spleen and kidneys under this item; record instead under Items 43-45. Do not report uncomplicated umbilical hernias or mild diastasis recti.

Item 43, Liver. Normal liver size is defined as two centimeters or less below the costal margin in the right midclavicular line. If liver size is greater or consistency is unusual record as "other" and describe.

Item 44, Spleen. Normal spleen size is defined as being not more than one centimeter below the costal margin in the left anterior axillary line. A spleen greater in size or of unusual consistency should be recorded as "other" and described.

Item 45, Kidneys. The size and location of a palpable kidney should be described.

Item 46, Genitalia. Evaluate by inspection and palpation. Do not report circumcision. Any question of abnormality should be reported.

Item 47, Anal Sphincter reflex. Elicit by stroking the perianal region with a piece of cotton.

Item 48, Spine. Evaluate the spine by inspection, palpation and manipulation. If a pilonidal sinus or dimple is present it should be recorded under this item.

Items 49-55, Muscle-Skeletal System. Evaluate the structure and functional integrity of this system in each of the six areas listed on the form. Include an evaluation of joint motion. This item is not intended to reflect the function of the Central Nervous System (this is covered elsewhere) but rather is an observation of the anatomy and mobility.

Item 56, Motor Activity. Throughout the examination evaluate the spontaneous body movements of the child. For the purposes of this examination the following definitions are to be used:

(1) Tremulous or Jittery Movements. – This includes tremulous movements occurring spontaneously or in response to a stimulus. They appear principally in the arms and are to be distinguished from the more coarse myoclonic movements.

(2) Rapid Jerky Movements. – These are sudden nonrepetitive purposeless twitches or jerks.

(3) Myoclonic Movements. – These represent slow, gross rhythmic movements usually symmetrical and usually triggered by a stimulus.

(4) Writhing Movements. – These are sinuous, asymmetric stretching movements.

(5) Asymmetrical Movements. – These are movements which differ in degree or quality be-

tween the two sides of the body.

(6) Convulsions. – These are usually clonic or tonic movements which are spontaneous in nature but this term also includes unconscious or atonic spells. If the convulsive movement is localized to a definable area it is to be termed a localized convulsion.

Item 57, Do Not Write in this Space. This is to be used for data processing purposes. Please do not write here.

Item 58, Comments. Same as Item 24.

Item 59, Patient Identification. Same as Item 1.

Items 60-65, Tone. Muscle tone should be evaluated in each of the five areas listed on the form. Express tone as a numerical value using a scale of five as defined on the form. Flaccid paralysis should be coded with hypotonicity (1) and spastic paralysis with hypertonicity (5). If tone is symmetrical record only in "Bilateral" blank.

Item 66, Palmar Grasp. The examiner's finger is applied to the palm of the child's hand from the ulnar side. Sometimes a slight rubbing motion helps elicit the response. If not obtained try applying the finger from the radial side. Be hesitant to call the response absent until a number of attempts have been made.

Item 67, Plantar Grasp. The examiner's finger is applied to the medial side of the child's foot. Sometimes a slight rubbing motion helps produce the desired response. Be hesitant to call the response absent until a number of attempts have been made.

Item 68, Patellar Jerk. Evaluate patellar jerks with the child in supine position, hips and knees moderately flexed and head in midline with face forward. Use a reflex hammer.

Item 69, Ankle Jerk. Evaluate ankle jerks with child in supine position. Use a reflex hammer.

Item 70, Ankle Clonus. Evaluate with child in supine position. The child's foot should be dorsiflexed by sudden firm pressure on the ball of the foot. If clonic movements occur check "other" and describe the intensity and approximate number.

Item 71, Hearing Response. Test with a xylophone using high and low frequencies. The examiner's judgment must be used in determining what response indicates the child hears the sound.

Item 72, Stepping. This is the observation of the infant's response when placed in an erect position with the soles of his feet touching a flat surface. This response is elicited by holding the child erect and placing the soles of both feet on a flat surface. A walking, stepping or jumping response is expected. If such a response is not obtained, it is desirable to incline the child's head, shoulders, and trunk slightly forward and, by rotating the child's trunk alternatingly, simulate a walking motion. The child will be expected to place one foot ahead of the other alternately in a pseudo-walking motion. The normal recording for this item is "present bilaterally and symmetrically." If scissoring is observed check the corresponding box.

Item 73, Placing. This is the observation of the child's response when being held in an erect position, the dorsum of both feet drawn under the lower edge of a moderately sharp surface such as the edge of a desk or examination table. The child is expected to lift both feet and place them on top of this surface. If such a response is obtained the normal item "present bilaterally and symmetrically" should be checked.

Item 74, Response to Image in Mirror. Hold a mirror (Bayley Test Mirror) close enough that the child may reach it easily taking care that it is his own image he sees and not his mother's. Record the child's response to his image in the appropriate box.

Item 75, Comments. Same as Item 24.

Item 76, Patient Identification. Same as Item 1.

Item 77, Response to a Red Ring. As child lies on back suspend a red ring (Bayley Test Red Ring) by the string before the child within easy reaching distance. His response to the ring should be recorded by checking the appropriate box. The categories are arranged in a descending order of development. Check only the highest level of development.

Item 78, Motor Skills. Check the appropriate "yes," or "no," or "unknown" box after each of the categories.

Item 79, Sitting with Support. Evaluate the child's

posture when sitting with support. Sitting with support is defined as the position the child is in after being pulled from a supine to a sitting position by traction on the arms. The test begins with the child lying supine. The examiner grasps the child's hand and forearms and pulls the child gently forward to a sitting position. This position, with the examiner holding the child's hands, should be maintained for approximately 15 seconds. Evaluate both head control and spine position. If spine position is either "erect" or "slight kyphosis only" check the corresponding "yes" box. If there is marked kyphosis or inability to maintain sitting position, check "Spine erect . . . . ., No."

Item 80, Predominant Position of Hands. The usual position of the child's hands when he is relaxed and not crying or agitated should be recorded by checking the appropriate box under this item.

Item 81, Cry. If the child does not cry spontaneously, attempt to make it cry. If unable to make the child cry, check the box "absent." If the child cries spontaneously, consider such unusual qualities as "high pitched," "feeble," "whining," "hoarse," or "stridulous" in evaluating whether the cry is normal or other, and check the appropriate box.

Item 82, Vocalization. Evaluate the child's vocalization. If the child coos or laughs check the first box regardless of other sounds made. If sounds other than cooing or laughing are the only ones heard check the second box. If no sounds are heard check the third box. No comments are necessary.

Item 83, M. C. Evaluation (Maternal-Child Relationship Evaluation). The following four items (84-87) provide for a systematic evaluation of certain aspects of the maternal-child interaction as observed by the pediatrician. Each item has a five-point scale representing three grades of reaction: Appropriate, Moderately inappropriate or unusual, Definitely inappropriate or extremely unusual. The center grade (box 3) represents the response which the examiner feels is appropriate to the situation, the intermediate categories (box 2 and 4) represent moderate grades of the inappropriate responses indicated by the captions, and the extreme categories (boxes 1 and 5) represent the extreme grades of the inappropriate responses. The box labeled "NE" refers to not evaluated, e.g., mother not present.

The response designations on the form are given in cryptic abbreviations to minimize chances of the mother accidentally reading and interpreting these items unfavorably.

For further elaboration of this section see manual PS-5 (Maternal Behavior in Testing Situation) dated 11/60.

Item 84, Responsiveness to Child's Physical Needs. This represents the examiner's evaluation of the mother's perception of and care of the child's needs, such as feeding, protection from cold, change of diapers, etc. The categories are:

(1) Mother seemed unaware of and *unresponsive* to child's needs.

(2) Mother was slow in recognizing and responding to child's needs.

(3) Appropriate *recognition* and care of child's needs.

(4) Overly absorbed with child's needs, overprotective in moderation.

(5) Extremely *absorbed* with child's needs, overly solicitous, overprotective in the extreme.

Item 85, Mother's Focus of Attention During Examination. The categories of classification are:

(1) Mother centered all attention on *child* and tried to keep child's attention on her, excluding both the examiner and test material from the situation.

(2) Mother accepted presence of examiner and the fact that test material was interesting to the child, but mother tried to involve herself with these foci of interest.

(3) Appropriate attention to entire *situation*. Mother was comfortable in letting child respond to examiner and materials.

(4) Mother occasionally interrupted examination to talk about her own perceptions of and reactions to the situation.

(5) Mother demanded that all attention be centered on *herself*, distracting the examiner from the child; disregarded test materials and focussed on events and problems extraneous to the situation.

Item 86, Attitude Toward Child's Test Performance. The categories of this dimension are:

(1) Mother seemed completely *indifferent* to child's performance.

(2) Mother showed brief and fleeting interest in child's performance, but this was done "politely" as though she felt this was expected of her; played role of a passive observer throughout.

(3) *Intermediate.* Mother seems pleased with child's successes and indicated this by smiling, etc.; accepted failures realistically when material and requests were obviously beyond child's abilities.

(4) Mother responded with excessive pride to child's successes; minimized any failures by child.

(5) Mother was overly absorbed in child's performance; *defensive* of child's failures as due to unfamiliarity with material; demanded constant praise from examiner; criticized examiner and test procedures for being unfair to child.

Item 87, Child's Appearance. This represents the examiner's evaluation of the general care the child gets as reflected by cleanliness, grooming, clothing, skin lesions, etc. The categories for this dimension are:

(1) *Poorly cared for,* neglected.

(2) Moderate degree of (1).

(3) Appearance reflects *appropriate* care and attention to appearance.

(4) Moderately overdone.

(5) *Overdone* to an extreme. Child seemed excessively dressed up, to the point of discomfort; child seemed to be a vehicle for clothes of which the mother was very proud.

Item 88, Comments. Same as Item 24.

Item 89, Patient Identification. Same as Item 1.

Item 90, Neurological Abnormalities. If the examiner considers the child to be completely normal neurologically the first box "None" should be checked.

If, on the basis of his examination, the examiner has reason to feel that the child is not completely normal neurologically, but cannot be classified as a definite clinical syndrome or "Neurologically Abnormal Child," the second box "Neurologically Suspicious..." should be checked.

If the examiner is able to state a definite or provisional diagnosis of a recognized syndrome, or feels the child is definitely neurologically abnormal but doesn't at this time fit into any diagnostic category, the third box "Neurologically Abnormal Child" should be checked.

Descriptions of suspected or definite neurological abnormalities deserve the most careful attention to completeness and specificity.

Item 91, Non-neurological Abnormalities. (Check all that apply.) This item calls for the examiner to summarize and comment on all abnormalities or deviations from the ideal, with a few exceptions. These *exceptions* are:

(1) Neurological abnormalities noted and described in Item 90.

(2) Mongolian spots and "stork bites."

(3) Small or uncomplicated umbilical hernias.

(4) Uncomplicated diaper rash or other minor acute skin conditions.

(5) Minor acute upper respiratory infections.

If the examiner considers the child to be completely normal, aside from any of the exceptions listed in the preceding paragraph, the first box "None" should be checked.

The second box "Minor Abnormalities or Deviations" should be checked if there is definitely present any deviation from the ideal state (other than the exclusions listed above) which is considered by the examiner to be of questionable or little significance. Examples of conditions in this category are:

(1) Pigmented nevi.

(2) Epicanthic folds or supernumerary digits.

(3) Undescended testes or hydrocele.

(4) Tibial torsion or correctable metatarsus varus.

If there is a suggestion of an abnormality which cannot be definitely ruled in or out by the physical examination and, which the examiner feels may be of significance to the child's health if present, the third category "Questionable Abnormalities" should be checked. Examples of situations which should be classified in this category are:

(1) Suspicion of congenital heart disease.

(2) Suspicion of congenital dislocation of the hip.

(3) Suspicion of cretinism.

If there is definitely present an abnormality which the examiner feels is of major importance to the child's health, the third category "Definite Major Abnormalities" should be checked. This should include conditions which the examiner can state only as provisional diagnoses, provided he is reasonably confident that his impression will be corroborated by further studies or subsequent examinations.

Item 92, Unsatisfactory Conditions for Examination. This provides the examiner with the opportunity to specify any unsatisfactory conditions which may have existed during the examination such as, unusually irritable child, interfering mother, etc.

Item 93, Disposition. Indicate whether findings on this examination indicate further examinations or tests. If further evaluation has been proposed or scheduled indicate what type.

Item 94, CP-5 Attached. Check whether or not supplemental information on CP-5 accompanies the form.

Item 95, Medical Editor's Comment. Reserved for comments of the Medical Editor. This may be completed after supplemental information from additional diagnostic studies, if any, are available.

Item 96, Comments. Same as Item 24.

NO NUMBER — NO DATE on original

blue

superseded by COLR-3004-10 rev. 10-60

FOUR-MONTH PEDIATRIC EXAMINATION

INSTRUCTIONS: Every numbered item should be checked (√). If any normal, findings should be checked (√) and described in margin or right.

1. EXAMINED BY	2. TIME
3. STATUS	4. DATE (Mo-Day-Yr)
5. WEIGHT	6. BODY TEMP. (If taken)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reasons for not evaluating any item.

7. LENGTH

8. UPPER SEGMENT (Crown-Symphysis) _____

9. LOWER SEGMENT (Symphysis-Heel) _____

10. SKIN

- 0 NORMAL COLOR

ABNORMAL

- 1 RASH
- 2 CYANOSIS
- 3 JAUNDICE
- 4 PALLOR
- 5 OTHER ABNORMALITIES (Specify)

11. RESPIRATIONS – RATE (Resting) _____

- 0 NORMAL
- 9 ABNORMAL, (Describe)

12. CHEST – CIRCUMFERENCE _____

- 0 SYMMETRICAL
- 1 ASYMMETRICAL

13. LUNGS

- 0 NORMAL TO PERCUSSION AND AUSCULTATION
- 9 OTHER (Specify)

14. HEART RATE – (Resting) _____

15. BLOOD PRESSURE – RIGHT ARM (Patient lying down – by palpitation) _____

16. HEART

- 0 NORMAL

ABNORMAL

- 1 IRREGULAR RHYTHM
- 2 MURMUR
- 3 THRILL
- 4 ABNORMAL SOUNDS
- 5 ABNORMAL SIZE
- 9 OTHER (Specify)

NOTE: This form was originally printed without PHS number and date in BLUE. It was also printed in YELLOW. It was superseded by the COLR-3004-10 (rev. 10-60) on YELLOW paper — and superseded by the use of white paper.

Department of Health, Education, and Welfare
Public Health Service

(PED-10) PAGE 1 OF 2

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

17. ABDOMEN
- ☐ 0 NORMAL
- ABNORMAL
  - ☐ 1 ABNORMAL DISTENSION
  - ☐ 2 ABNORMAL MUSCULATURE
  - ☐ 3 MASSES

18. LIVER
- ☐ 0 NOT PALPABLE
- ☐ 1 PALPABLE (Describe)

19. SPLEEN
- ☐ 0 NOT PALPABLE
- ☐ 1 PALPABLE (Describe)

20. KIDNEYS
- ☐ 0 NOT PALPABLE
- ☐ 1 PALPABLE (Describe)

21. GENITALIA
- ☐ 0 NORMAL
- ☐ 1 ABNORMAL – MALE
- ☐ 2 ABNORMAL – FEMALE

22. HEAD – CIRCUMFERENCE _____

23. SHAPE – ☐ 0 NORMAL
- ☐ 1 ABNORMAL

24. FONTANEL – ANTERIOR
- ☐ 0 OPEN (Give size) _____
- ☐ 1 CLOSED

– POSTERIOR
- ☐ 0 OPEN (Give size) _____
- ☐ 1 CLOSED

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

25. EARS

26. RIGHT
- 0 NORMAL
- ABNORMAL
  - 1 EXTERNAL FORM
  - 2 CANAL
  - 3 DRUM
  - 9 OTHER (Specify)

27. LEFT
- 0 NORMAL
- ABNORMAL
  - 1 EXTERNAL FORM
  - 2 CANAL
  - 3 DRUM
  - 9 OTHER (Specify)

28. NOSE
- 0 NORMAL
- 1 ABNORMAL

29. MOUTH AND PHARYNX
- 0 NORMAL
- 1 ABNORMAL

30. EYES

31. RIGHT
- 0 NORMAL
- ABNORMAL
  - 1 PUPIL
  - 2 CORNEA
  - 3 LENS
  - 9 OTHER (Specify)

32. LEFT
- 0 NORMAL
- ABNORMAL
  - 1 PUPIL
  - 2 CORNEA
  - 3 LENS
  - 9 OTHER (Specify)

33. PUPILS

	RIGHT	LEFT
SIZE (Use dots)	34. _____	35. _____
DIRECT REACTION TO LIGHT	36. 0 PRESENT	37. 0 PRESENT
	1 ABSENT	1 ABSENT

38. NECK
- 0 NORMAL
- ABNORMAL
  - 1 RANGE OF MOTION
  - 2 MASSES
  - 9 OTHER (Specify)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

39. SKELETAL SYSTEM

40. ARMS AND HANDS

- ☐ 0 NORMAL
- ☐ 1 ABNORMAL

41. LEGS AND FEET

- ☐ 0 NORMAL
- ☐ 1 ABNORMAL

42. SPINE

- ☐ 0 NORMAL
- ☐ 1 ABNORMAL

43. NEUROMUSCULAR SYSTEM

44. MOVEMENTS OF FACE

- ☐ 0 PRESENT AND SYMMETRICAL

ABNORMAL:

- ☐ 1 ABSENT
- ☐ 2 ASYMMETRICAL
- ☐ 3 OTHER (Specify)

45. BODY MOVEMENTS

- ☐ 0 NORMAL

ABNORMAL:

- ☐ 1 TREMULOUS
- ☐ 2 RAPID, JERKY MOVEMENTS
- ☐ 3 WRITHING MOVEMENTS
- CONVULSIONS
  - ☐ 4 LOCAL
  - ☐ 5 GENERALIZED
- ☐ 6 OTHER (Specify)

46. MOVEMENTS OF UPPER EXTREMITIES

- ☐ 0 NORMAL (Symmetrical with normal range of motion)
- ☐ 1 ABNORMAL

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reasons for not evaluating any item.

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

Identify remarks by number of item. Every abnormality which is checked (Y) should have some description. Give reason for not evaluating any item.

47. MOVEMENTS OF LOWER EXTREMITIES
- 0 NORMAL (Symmetrical with normal range of motion)
- 1 ABNORMAL

48. BODY TONE

49. NECK – 0 NORMAL
- 1 FLACCID (Limp)
- 2 HYPERTONIC (Rigid)

50. TRUNK – 0 NORMAL
- 1 FLACCID (Limp)
- 2 HYPERTONIC (Rigid)

51. UPPER EXTREMITY – 0 NORMAL
- 1 FLACCID (Limp)
- 2 [illegible]

52. LOWER EXTREMITY – 0 NORMAL
- 1 FLACCID (Limp)
- 2 HYPERTONIC (Rigid)

53. SUCK (Evaluate with finger)
- 0 STRONG
- 1 WEAK
- 2 ABSENT

54. PALMAR GRASP (Stimulate – finger applied to ulnar side of palm)

55. RIGHT	56. LEFT
0 PRESENT	0 PRESENT
1 ABSENT	1 ABSENT

2 ASYMMETRICAL

57. PATELLAR JERK

58. RIGHT	59. LEFT
0 PRESENT	0 PRESENT
1 ABSENT	1 ABSENT

2 ASYMMETRICAL

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

60. ANKLE JERK –

61. RIGHT
- 0 PRESENT
- 1 ABSENT

62. LEFT
- 0 PRESENT
- 1 ABSENT

- 8 ASYMMETRICAL

63. ANKLE CLONUS –

64. RIGHT
- 0 ABSENT
- 1 PRESENT

65. LEFT
- 0 ABSENT
- 1 PRESENT

- 8 ASYMMETRICAL

66. TONIC NECK (Elicit by moving head slowly to Child's right or Child's left. Note position 30 to 60 seconds after head movements)

67. HEAD MOVEMENT TO RIGHT

68. EXTENSION PRESENT IN
- 7 ALL ARMS
- 6 ALL LEGS
- 5 OCCIPUT ARMS
- 4 OCCIPUT LEGS
- 0 ABSENT

69. FLEXION PRESENT IN
- 7 ALL ARMS
- 6 ALL LEGS
- 5 OCCIPUT ARMS
- 4 OCCIPUT LEGS
- 0 ABSENT

70. PELVIC ROTATION
- 1 AWAY FROM JAW
- 2 TOWARD JAW
- 0 ABSENT

71. RESPONSE
- 1 OBTAINED WITH EASE
- 2 OBTAINED WITH DIFFICULTY
- 0 NO CONSTANT PATTERN

72. HEAD MOVEMENT TO LEFT

73. EXTENSION PRESENT IN
- 7 ALL ARMS
- 6 ALL LEGS
- 5 OCCIPUT ARMS
- 4 OCCIPUT LEGS
- 0 ABSENT

74. FLEXION PRESENT IN
- 7 ALL ARMS
- 6 ALL LEGS
- 5 OCCIPUT ARMS
- 4 OCCIPUT LEGS
- 0 ABSENT

75. PELVIC ROTATION
- 1 AWAY FROM JAW
- 2 TOWARD JAW
- 0 ABSENT

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

76. NECK (Support child under trunk and head. Let child's head drop back about 30 degrees.)

77. RESPONSE OF ARMS
- 0 NORMAL (Flexor and extensor components symmetrically present)
- 1 FLEXOR COMPONENT ABSENT
- 2 ASYMMETRICAL
- 3 OTHER (Specify)

78. RESPONSE OF LEGS
- 0 FLEXOR
- 1 OTHER (Specify)

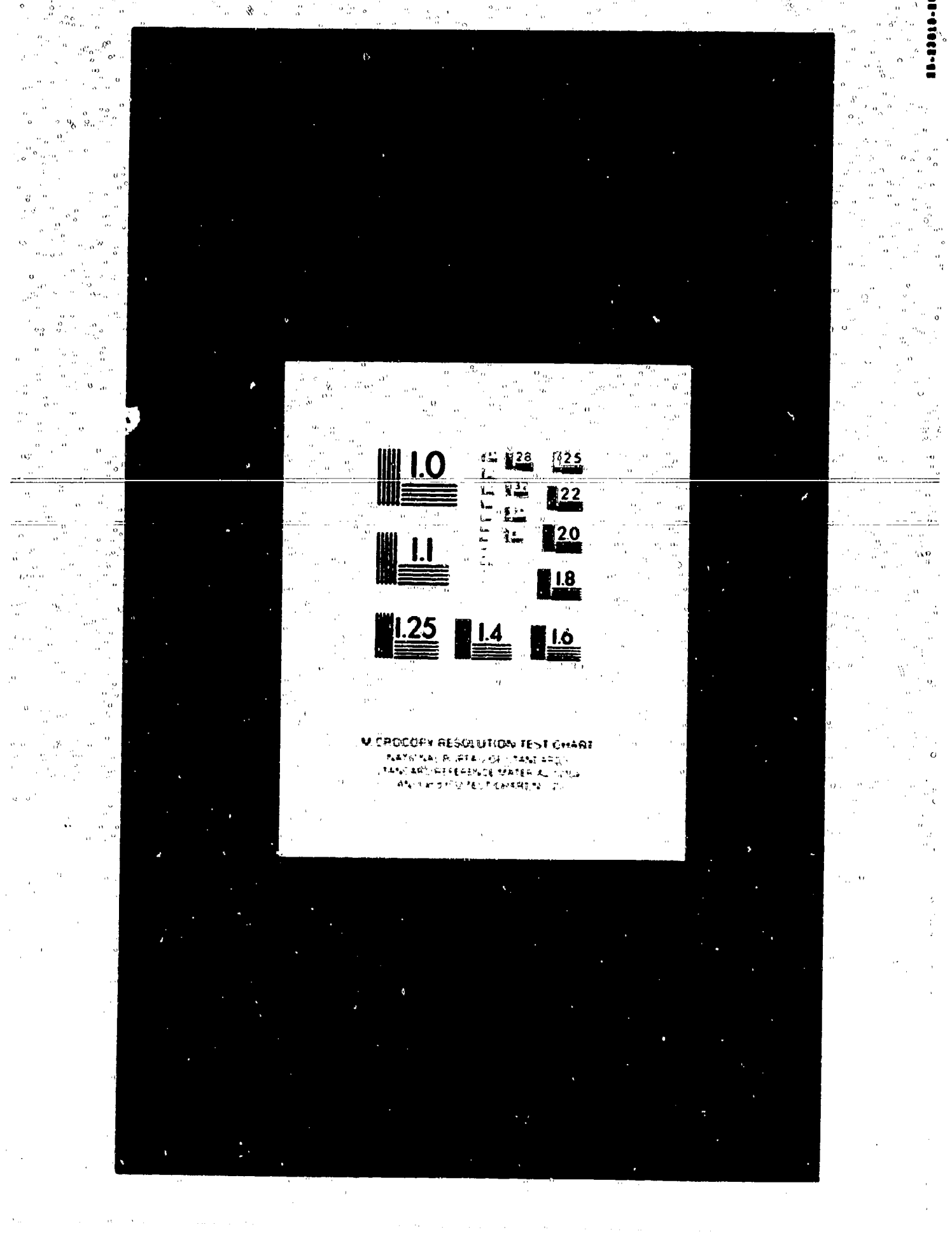
79. RESPONSE
- 1 OBTAINED WITH EASE
- 2 OBTAINED WITH DIFFICULTY
- 3 NO CONSTANT PATTERN

80. HEARING RESPONSE
- 0 NORMAL
- 1 QUESTIONABLE
- 2 ABNORMAL

81. VISUAL RESPONSE -- FOLLOWING OF OBJECTS
- 0 PRESENT
- 1 ABSENT

82. DIAGNOSIS
- 0 NORMAL
- ABNORMAL
- 2 CONGENITAL MALFORMATION (Describe)
- 3 ABNORMAL DEVELOPMENT (Describe)
- 4 INJURY (Describe)
- 5 OTHER (Describe)

Identify remarks by number of item. Every observation which is checked (✓) should have some description. Give reasons for not evaluating any item.


1.0
1.1
1.25
1.4
1.6
2.8
2.5
2.2
2.0
1.8
MICROCOPY RESOLUTION TEST CHART

CONTINUED ON NEXT FICHE