

Date _____ Patient # _____

Name _____ Date of Birth _____

Address _____

Lives with: 1 parent 2 parents Other caregiver

Others (including siblings) _____

May release information to: (parent, guardian, other family -- list) _____

Parental concerns: _____

Changes in child's health since last visit: _____

GENERAL HEALTH:

Nutrition: Breast: _____ times/day

Bottle _____ oz/day

YES NO

Drink from a cup?

Table/finger foods?

Solids: Cereals Fruits Vegetables Meats

Juice _____ oz/day

Daily oral health care? Yes No No teeth

Dental visit?

Elimination: Stooling: soft, easy to pass BMs _____

Sleep: _____ hours through the night

YES NO

Problems? Night feedings? _____

Bottle to bed?

DEVELOPMENT: Screen or refer if concerns or "No" response on milestones in **bold type**

YES NO

Strong attachment to primary caregiver

Points or uses other gestures such as waving*

Babbles, says "ma-ma" "da-da" specifically (13 months)*

Picks up Cheerio with thumb and finger

Understands "no" or their name*

Pulls to standing position

Gets to sitting position (*autism risk)

May walk without support

Family concerns about speech, learning, motor skills, behavior? _____

MEDICAL HISTORY:

Allergies: _____ Meds: _____

Major medical illnesses/special health care needs: _____

Hospitalizations/Surgeries: _____

FAMILY HISTORY: Reviewed and updated

SOCIAL HISTORY:

Childcare: _____

FAMILY RISK FACTORS:

Changes in family since last visit: _____

Stress: How much stress are you and your family under now?

None Slight Moderate **Severe**

What kind of stress? Relationships Drugs Alcohol

Violence/Abuse Lack of help Financial

Health Insurance Child care Other _____

How stressful is caring for your child?

None Slight Moderate **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless? No Sometimes **Often**

In the past month have you/partner felt little interest or pleasure in doing things? No Sometimes **Often**

ANTICIPATORY GUIDANCE: Check if discussed

FAMILY WELL-BEING:

Time for self and partner. Family-work balance. Support

"Tell me about your family traditions"

Limit screen time for older siblings <2h, monitor content

Family meals, bedtime routine - include reading

BEHAVIOR:

Establish daily routine with meals, snacks, naps, bedtime

Continue to read, sing, and play with child (**No** TV, videos)

Consistent behavior management: distraction, positive reinforcement, "time outs"

Ignore temper tantrums

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

Transition to soft table food, wean from bottle.

Eating with family at table (secure seating). 3 meals and 2 snacks - no grazing or carrying cup around

Offer healthy food, child decides amount. Encourage feeding self

Choose a dentist and first visit by 12 months or 1st tooth

Brush teeth 2 times a day with smear of fluoride toothpaste. If still has bottle, offer only water

SAFETY:

As mobility increases, safety concern also increases.

Review car restraints – continue rear-facing as long as possible.

Child Safety Seat Inspection Locator: 866-732-8243, www.seatcheck.org

Lead exposure, water & gun safety.

If smoking in home: discuss quitting, limiting exposure

PHYSICAL EXAMINATION

Vital signs: P: _____ R: _____ T: _____ Weight _____ (_____%)

Length _____ (_____%) Wt/Length _____ % Head circumference _____ (_____%)

N Abn *Comment on abnormal findings*

- General appearance _____
- Behavior/interaction with family _____
- Skin _____
- Head/scalp _____
- Ears _____
- Eyes _____
- Nose _____
- Mouth/Throat _____
- Teeth _____
- Neck _____
- Back/Chest _____
- Lungs _____
- Heart _____
- Abdomen _____
- Genitalia _____
- Musculoskeletal _____
- Neurologic _____

Results reviewed: (outside info, lab, etc.) _____

Impression: _____

PLAN OF CARE (see Anticipatory Guidance)

- Fluoride varnish given** (if high risk, such as all Title 19 patients)

Immunizations: Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: No Yes

See current guidelines www.immunize.org/aap

LAB: Lead Hb or Hct other if indicated _____

Developmental Follow-up No delays Follow-up in office Referral

Referral: (if indicated) _____

Central referral numbers: For assistance with care coordination, transportation, or health information for children **birth through age 21:**
Healthy Families Line 1-800-369-2229

For referral of children **birth to age 3** with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts: _____

Return appointment: _____

Signature _____ Date _____