

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: _____

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**

GENERAL HEALTH:

Nutrition: Breast: _____ times/day

Cow's milk _____ oz/day

YES NO

Bottle? _____ times/day

Eats all food groups, incl. fruits and vegetables?

Juice _____ oz/day

Daily oral health care

Has had 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

Good eye contact*

Imitates activities

Points or gestures for needs*

Follow simple commands "stop" or "give me"

Says at least one word besides "ma-ma" or "da-da"*

Puts block in cup

Walks well without support

May take step backwards

(*autism risk)

Family concerns about development, behavior, motor or social skills: _____

MEDICAL HISTORY:

Allergies: _____ Meds: _____

Major medical illnesses/Special health care needs: _____

Hospitalizations _____

Surgeries: _____

ANTICIPATORY GUIDANCE: Check if discussed

FAMILY WELL-BEING:

Discuss limits and BE CONSISTENT with all children

Family meals are important social times

Limit TV exposure, be aware of programming

Partner involvement; time for self, partner, each child

BEHAVIOR:

Expect NO impulse control this year from toddler

Emerging independence. Let choose between two options

Narrate actions, use simple, clear words and phrases

Read together. Reward successes. **Positive reinforcement!** 10 positives for every negative.

Remove temptations. Distract with alternatives. Behavior management for teaching/ protecting, not punishing

Time out for aggressive behaviors. **No** spanking.

Put to bed awake with comfort object. No bottle in bed.

Brief reassurance for night waking

NUTRITION / OBESITY PREVENTION / ORAL HEALTH

Feeds self: expect to be messy! (NO foods easy to choke on)

Sit when eating; no soft drinks; limit juice

Obesity prevention

Dental home established? Ensure **family** dental health.

Brush twice daily. No bottle!

SAFETY:

"Toddler proof" home: gates across stairways, window guards; check smoke / CO detectors; no guns.

Do not store dangerous substances in safe-looking containers.

Hot liquids, matches, poisons out of reach.

Seasonal safety – sunscreen, hats, bug spray, wading pools; frostbite, emergency kit in car.

Lower crib mattress to bottom rung.

Poison Control Center 1-800-222-1222.

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: (if indicated) 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 _____