

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 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 visitElimination:  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**; Developmental and Autism screening recommended

YES NO

  Good eye contact\*  Interested in other children\*  Looks at object when someone points to it\*  Says three words other than "ma-ma" & "da-da"\*  Follows one step commands without gesture\*  Stacks at least two blocks  Uses cup  May use spoon or fork  Walks well, runs  May walk upstairs

(\*autism risk)

Family concerns about speech, learning, behavior, social or motor skills: \_\_\_\_\_

**MEDICAL HISTORY:**

Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Major medical illnesses: \_\_\_\_\_

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  SevereWhat 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  OftenIn 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:** Short family outings. Both parents spend time w/ each child. Allow older children their own space and toys, time with parents Monitor TV time and programming Acknowledge sibling conflict, try not to take sides. Don't allow aggressive behaviors**BEHAVIOR:** Set consistent limits. Brief timeouts, simple statements, no discussion. Praise good behavior Talk/sing/read to child. Ask child questions. No TV, videos. Support bilingual language usage. Toilet training - Start only when child is ready (dry for 2 hrs, knows wet and dry, pulls pants up & down.) Key is patience and child comfort - must have soft BMs; use same routine each day. Enjoys playing with other kids.**NUTRITION / OBESITY PREVENTION / ORAL HEALTH:** Encourage feeding self and using cup- expect to be messy! Sit when eating. Obesity prevention May become picky in food preferences - repeatedly offer new healthy foods, let child choose. No soft drinks. Limit juice. No bottle, especially in bed. Brush with small (< pea) amount of fluoride toothpaste.**SAFETY:** Car seat always in back seat. Never leave alone in car. Constant supervision in home and car, near water. Child will climb, pull cords and tablecloths, and get into unsecured cabinets/bags. Keep medicines and cleaning products high and locked Protect from hot liquids, surfaces (space heaters, irons, curling irons, grills), matches, guns Poison Control 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 \_\_\_\_\_

Developmental Screening (ASQ, other) \_\_\_\_\_   Autism Screening (M-CHAT, other) \_\_\_\_\_

**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](http://www.immunize.org/aap)

**LAB:**  Lead  Hb or Hct  other if indicated \_\_\_\_\_

**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 \_\_\_\_\_