

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
 Vit D (until 32oz formula per day)

Elimination:

Stooling: soft, easy to pass BMs

Sleep: _____ hours through the night

YES NO

Place on back to sleep

Put to bed awake at night and naps

Bottle to bed?

Problems: _____

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

YES NO

Social smile

Coos and laughs interactively

Able to be comforted

Tracks and follows with eyes

Good head control

Opens hands, grasps rattle

Moves arms and legs equally

Lifts head 90 degrees in prone

May roll over and bear weight on legs

Family concerns about growth, development, 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:

Make time for self, partner and family/friends. Quality child care.

Discuss adjustment of older sibs

BEHAVIOR:

Range of infant behaviors and temperaments. Calming strategies.

Bedtime and feeding routines enhance sense of security.

Teach infant to put self to sleep. Crying won't hurt baby.

NUTRITION / ORAL HEALTH:

Solid food readiness, don't share spoon.

Ask about supplements, herbs, and vitamins

No bottle propping or bottle in bed.

Discuss teething & family oral health.

SAFETY:

May roll and put things in mouth (small objects, plastic bags)

Discuss lead in home (espec. before 1960) & parental occupational hazards - farmers, plumbers, welders

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)

Immunizations: Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: No Yes

See **current guidelines** www.immunize.org/aap

LAB: (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 _____