

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

- Drinking from cup?
 Solids?: Cereals Fruits Vegetables
 Meats Table / fingerfoods
 Juice? If so, _____oz./day

Daily oral health care? Yes No No teeth**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

- Interacts with family by smiling and vocalizing**
 Shows range of emotions.
 Turns to voice,
 Babbles and coos,
 Rolls over both ways
 Reaches for objects
 No head lag when pulled to sitting
 Bears weight on legs
 May sit without support

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 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:**

- Encourage support system, time for self, partner, family.
 Consistency in routines at home and in daycare

BEHAVIOR:

- Encourage reading, singing, and talking with infant.
 Discuss causes of fussiness – overstimulation, fatigue, boredom.
 Sleep routine – self-calming, putting self to sleep. What to do if wakes during night

NUTRITION / OBESITY PREVENTION / ORAL HEALTH

- Feed infant based on hunger cues. Soft finger foods.
 Avoid milk, fish, shellfish, egg whites, peanuts, and nuts
 Limit juice < 2 oz a day. Begin sippy cup.
 No bottles in bed, no bottle propping.
 Smear of fluoride-containing toothpaste and soft toothbrush when teeth erupt.

SAFETY:

- Never leave infant alone near water, on high places (changing table, couch, bed, etc).
 Childproof home, barriers in front of heat sources.
 Lower crib mattress – may pull to stand, back to sleep, no loose bedding.
 Poison control on every phone: 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)

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 _____