

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? Table/finger foods?Solids: Cereals Fruits Vegetables Meats Juice _____oz/dayDaily 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

 Interacts with family by smiling and vocalizing Expresses emotions. Waves "bye-bye" or plays "pat-a-cake". **Babbles, repeats syllables like ba-ba, na-na** **Imitates sounds** **Transfers object to other hand** **Feeds self cracker** May pick up Cheerio **Sits well without support** Stands holding on to stable objectFamily concerns about development or 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:** Discuss support system / childcare / community resources**BEHAVIOR:** Sleep routines. Lower mattress in crib - may stand or climb. Emerging independence and separation anxiety. Learning cause /effect. Allow child to safely explore environment – supervision! Continue to read, sing, and play with child. No TV, videos. Thoughts about discipline? Family agreement? Recommend consistency and distraction**NUTRITION / OBESITY PREVENTION / ORAL HEALTH** Safe finger foods. Exposure to new tastes & textures. 3 meals, 2-3 snacks a day. Eat with family at table (secure seating). Increase cup use, decrease bottle Smear of fluoride-containing toothpaste and soft toothbrush**SAFETY:** No poisons under kitchen sink. Discuss wading pools and guns Barriers around heat sources, windows, and stairs. Electrical outlet covers. Remove choking hazards, tablecloths. Rear-facing car seat until 1 year **and** 20 pounds. Always in back. 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) _____

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 _____