

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/Dental:**

YES NO

- Bottle or pacifier? \_\_\_\_\_times/day
- Cow's milk \_\_\_\_\_oz/day
- Juice \_\_\_\_\_oz/day
- Daily eats all food groups, incl. fruits & veggies?
- 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**; Recommend autism screening; Recommend developmental screening if no 30-mo. visit.

YES NO

- Plays along side other children**
- Pretend play such as feeding a doll\***
- Says 50 words or more\***
- Puts 2 words together, such as "more juice" (not just repeating)\***
- Knows some body parts**
- Points to picture**
- Stacks 4-5 blocks** \*(autism risk)
- Walks up stairs one step at a time, runs, kicks ball**

Family concerns about behavior, speech, learning, 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  **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:**

- Take time for self and with partner. Participate in parent learning / support groups.
- Family physical activities
- Help children resolve conflicts, express emotions

**BEHAVIOR:**

- Praise good behavior! Set consistent limits. Brief timeouts.
- Playgroups and socialization, but should not expect to share toys
- Hug / talk / read / play together. Ask questions.
- Support bilingual language usage.
- Discourage almost all "screen time." If any, watch together and talk about what you see
- Toilet training: Start only when child is ready. Patience. Use same routine each day.
- Expect curiosity about genitals.
- Offer choices between 2 acceptable options

**NUTRITION / OBESITY PREVENTION / ORAL HEALTH:**

- Offer variety foods, let child decide. Avoid struggles.
- Structure 3 nutritious meals and 2 snacks per day.
- Daily sit-down meals with family.
- Brush teeth twice daily with small amount of FI toothpaste.
- Dental home

**SAFETY:**

- Constant** supervision. Keep away from lawn mowers, overhead garage doors, driveways, streets, etc.
- Review car restraints. Model safe car behaviors.
- Climbing precautions.
- Is home fire safe? Fire/smoke, CO detectors.
- Childproof home – hot liquids, matches, lighters, guns.
- Water safety near tubs, pools, buckets.
- If smoking in home: discuss quitting, limiting exposure

**PHYSICAL EXAMINATION**

**Vital signs:** P: \_\_\_\_\_ R: \_\_\_\_\_ T: \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Weight \_\_\_\_\_ (\_\_\_\_\_% ) Height \_\_\_\_\_ (\_\_\_\_\_% )  
 BMI \_\_\_\_\_ (\_\_\_\_\_% )

**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:**  UTD - not indicated  Missed previous well visit; being caught up

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 (Assess risk)  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 \_\_\_\_\_