

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 and veggies?
- Daily oral health care**
- Has had yearly dental visit**

Elimination:  Stooling: soft, easy to pass BMs \_\_\_\_\_

Sleep: \_\_\_\_\_ hours through the night

YES NO

- Problems? Night feedings? \_\_\_\_\_

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

YES NO

- Plays with other children (not just next to)\***
- Imaginative or pretend play\***
- Helps with dressing, washes hands**
- Uses 2-4 word sentences**
- Speech 75% understandable**
- Names animal pictures**
- May imitate vertical line or copy circle**
- Throws ball over head**
- Jump with both feet (\*autism risk)**
- Uses 2-4 word sentences\***
- May pedal tricycle if available

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:**

- All caregivers consistent in discipline -show respect, reinforce limits.
- Encourage family activity & involve child in choices.
- Show affection; teach expression and handling of feelings.
- Don't allow aggressive behavior.
- Teach sharing and taking turns.

**BEHAVIOR:**

- Play opportunities outside of home; discuss child's experiences
- Read wherever you go, not just books (signs, etc);  
Let child tell part of stories
- Encourage child's questions and give simple direct answers
- Expect & encourage fantasy play and interactive games.
- Limit screen time to 1 hour /day. Monitor, discuss inappropriate behaviors even in cartoons. NO TV or DVD in bedroom.
- Expect normal curiosity with genitals. Use correct terms and answer questions. Explain certain body parts are private.
- Discuss community programs, preschool, Head Start.

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

- Offer variety of healthy foods, low-fat dairy products.
- Avoid junk food; no soda.
- Daily family meals are important.
- Assist in brushing teeth twice daily until 7-8y.
- Dental visits twice yearly

**SAFETY:**

- Safety seat or booster with 5-pt harness until 40lbs.  
In back seat until 12 yrs
- Child Safety Seat Inspection Center:  
seatcheck.org or 1- 866-732-8243.
- Constant** supervision, including near playgrounds, windows, water, pets, driveways, strangers, and streets.
- Review guns, fire/CO safety.
- If smoking in home: discuss quitting, limiting exposure

**PHYSICAL EXAMINATION**

**Vital signs:** P: \_\_\_\_\_ R: \_\_\_\_\_ T: \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ Weight \_\_\_\_\_ ( \_\_\_\_\_ %) Height \_\_\_\_\_ ( \_\_\_\_\_ %)  
 BMI \_\_\_\_\_ ( \_\_\_\_\_ %) Vision Screening R 20/\_\_\_\_ L 20/\_\_\_\_ Hearing: Assess risk

**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)

- 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: Assess risk  Hb of 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 developmental delay or disability: **Check with local public school**

Handouts: \_\_\_\_\_

**Return appointment:** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_