

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

- Pacifier or thumb? _____
- Cow's milk _____oz/day
- Juice _____oz/day
- Daily eats all food groups, incl. fruits and vegies
- Twice daily brushing of teeth**
- Has had twice yearly dental visit**

Elimination: Stooling: soft, easy to pass BMs _____

Sleep: _____hours through the night

YES NO

- Problems? Eat during the night? _____

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

YES NO

- Family reports child can do what most 4-year-olds can do**
- Plays games with other children***
- Dresses self with help**
- Speaks in sentences***
- Speech is understandable to strangers**
- Understands "on" "under" "big" "little"**
- Copies a circle (*autism risk)**
- Balances on each foot for 2 seconds**

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:

- Limit screen time < 2 hours per day – Monitor programming.
- No TV or DVD in bedrooms.
- Family physical and educational activities – museums, zoos, community projects.
- Structure quiet bed time routine. Read or tell stories

BEHAVIOR:

- Discuss feelings and experiences, praise when sensitive to others' feelings
- Observe child's interactions with peers, offer suggestions, and model appropriate actions.
- Encourage and ask questions - respond with short, simple, factual answers
- Set appropriate limits, praise good behavior and accomplishments.
- Assign simple chores (picking up toys, setting table).
- Structured learning/play opportunities- preschool, play-groups, Sunday school, etc.
- Teach child correct terms regarding bodies, explain privacy, discuss "rules" of behavior re: adults

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- 5+ fruits & vegetables, 3+ low-fat milk / dairy, limit junk food, NO soft drinks.
- Model good eating habits, Family meal.
- Brush twice daily with FI toothpaste, have family dental home

SAFETY:

- Teach safety with adults - No adult should: tell child to keep secrets from parents; express interest in private; ask child for help with private parts.
- Review matches, lighters, guns.
- Teach pet, neighborhood, street, stranger safety, but **supervise** all activity near streets and driveways.
- Swimming lessons don't guarantee safety, keep within arms' length.
- 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: R _____ L _____

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: Lead: Assess risk 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 developmental delay or disability: **Check with local public school**

Handouts: _____

Return appointment: _____

Signature _____ Date _____