

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

- 3 servings of milk?
- 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
 Problems? YES NO

DEVELOPMENT:

School: Grade _____

Favorite subject of activity: _____

Problems: YES NO

YES NO

- Early reading
- Able to tell print numbers to 10, write name, know L / R
- Ties shoes
- Rides bike
- Following directions, begins to impose and follow rules

Family concerns about behavior, speech, learning, social, or motor skills: _____

Activities outside of school: _____

Peer relations: GOOD OK POOR

MEDICAL HISTORY:

Medications/supplements: _____

Allergies: _____

Major medical illnesses: _____

Hospitalizations _____

Surgeries: _____

FAMILY HISTORY: Reviewed and updated

SOCIAL HISTORY:

Childcare/after school care: _____

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 only if discussed

FAMILY WELL-BEING:

- Family fitness; limit screen time <2h, monitor content.
- Show affection in the family & model respect for all people.
- Discuss anger management, praise efforts for self-control.
- Family meals, maintain bedtime routine, including reading.
- Family rules, chores; Praise accomplishments.

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- Ensure good breakfast at home or at school.
- Balanced diet – fruits/veget, whole grains, healthy snacks
- Observe brushing, help floss. Dental exams every 6 months

BEHAVIOR:

- School:** talk about new experiences, friends, activities, possibility of bullying, or kids being “mean”.
- Visit school & playground, meet teacher. After-school care?
- Clearly state expectations and consequences –no threats, but consistently follow through with consequences
- Encourage child to make choices. Listen to child respectfully – will help in developing autonomy, independence
- Answer child's questions about sex, drugs in a straightforward manner with as much or as little info as child needs

SAFETY:

- School bus safety and rules.
- All** wheeled activity requires wearing well-fitting helmet:
- Booster seat in back seat. until ~4'9" tall, shoulder strap across shoulder, not neck, can bend at knees while sitting against seat back
- Teach home and emergency phone numbers, home address; home fire escape plan.
- Teach safety with adults - **NO** adult should:
 - tell child to keep secrets from parents
 - express interest in private parts
 - ask child for help with private parts
- 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 _____

Sexual Maturity Stage ____ breast (female) ____ genitals (male) ____ pubic hair (female & male)

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 _____

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 with developmental delay or educational concerns **3 yr through high school:**
local **Iowa Area Education Agency** www.iowaaea.org

Handouts: _____

Return appointment: _____

Signature _____ Date _____