

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

- Reading: types - early readers, chapter books
- Improving motor skills, enjoys team sports
- Ties shoes, writes legibly
- Imposes rules on games, understands intentional versus accidental

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:**

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 outings, family meal, positive interactions, individual undivided attention
- Media limitation, monitor content – help become “media literate” by watching with children and commenting on messages
- Household chores, responsibilities for all

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

- Be sure has healthy breakfast (3 meals per day); healthy snacks.
- No soda, <6 oz juice; >2 cups skim milk (or low-fat daily)
- Observe twice daily brushing, help floss, Dental exams q 6 mo
- Mouth guard with contact sports

**BEHAVIOR:**

- Discuss school, activities, interests, friends. Any bullying?
- Talk about feelings, worries
- Encourage competence/independence
- Answer child's questions about sex, drugs simply with as much or as little info as child needs

**SAFETY:**

- Booster seat until ~4'9" tall, shoulder strap across shoulder-not neck, can bend at knees while sitting against seat back
- ALWAYS wear helmet with wheeled activities.
- Teach danger of driveways. Still shouldn't ride alone in street
- Know child's friends and families, agree on supervision
- Fire safety-family escape plan, practice it. Water safety-learning how to swim does NOT insure safety; sunscreen
- Stranger safety – don't answer phone, door alone; before and after school supervision
- Gun safety (including BB guns)
- 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](http://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](http://www.iowaaea.org)

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

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

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