

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

- 3-4 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 and math at grade level?
- Improving motor skills, team sports
- Handles frustrations and anger appropriately
- Understands family and school rules, and consequences of not following

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 meal, positive interactions No TV during meals or in bedrooms
- Household chores, responsibilities – respect privacy of each member of the family
- Media limitation; monitor computer use, install safety filter ; promote “media literacy”
- Model admitting mistakes, asking forgiveness, dealing with anger or disagreements

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- Eat breakfast! Water rather than soda or juice
- Avoid junk food – eat healthy snacks.
- Brush twice, floss once. Dental exams every 6 months

BEHAVIOR:

- Discuss school, activities; needs quiet space for homework
- Discuss puberty, increase in personal hygiene
- Discuss tobacco, alcohol, other drugs
- Consistent expectations and consequences , balanced with plenty of affection and positive reinforcement.–
- Expect some early adolescent behavior – challenges to rules, conflicts over independence, refusal to participate with family

SAFETY:

- Helmet and other protective sports equipment –
- Pedestrian street safety
- Know friends & their families, cont to need supervision
- Make plan for personal safety if feels unsafe
- Stranger safety – don't answer phone, door alone; before and after school supervision
- Water safety , including flotation device if in boat
- Gun safety (including b.b. guns)
- Check smoke & CO detectors regularly
- 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 _____