

Name: _____ DOB: _____ Date: _____

Current Medications		Drug / Food Allergies			Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	HC	HR	Resp.	Temp.	Interpreter: Y / N
Past Medical History		Interval History			Nutrition		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Reaction to previous IMMS: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ F/u previous concern: <input type="checkbox"/> None _____		Sleep: <input type="checkbox"/> NL _____ <input type="checkbox"/> Bedtime routine <input type="checkbox"/> Sleeps in own crib Elimination: <input type="checkbox"/> NL _____ Behavior: <input type="checkbox"/> NL _____ Activity (playtime): <input type="checkbox"/> NL _____			Milk: _____ # oz/day : _____ Fruits: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Vegetables: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Meats: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Healthy snacks: <input type="checkbox"/> Yes <input type="checkbox"/> No Juice: <input type="checkbox"/> Yes <input type="checkbox"/> No Concerns: _____		
Social / Family History				Growth-Development			
Lives at home with: _____ Parent / child interaction: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Parents working outside home: <input type="checkbox"/> Mother <input type="checkbox"/> Father Child care: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Family / work balance: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				Cognitive: <input type="checkbox"/> NL _____ ● Follows simple commands; scribbles Physical: <input type="checkbox"/> NL _____ ● Drinks from cup; walks well; puts block in a cup		Language: <input type="checkbox"/> NL _____ ● Brings objects over to show you; waves good-bye; understands "no" Social: <input type="checkbox"/> NL _____ ● Imitates activities; listens to a story; may help in the house	
Parental Concerns: _____ _____ _____							
Physical Exam (checked <input type="checkbox"/> = normal)					Abnormal Findings		
<input type="checkbox"/> General (Alert, NAD) <input type="checkbox"/> Head (No deformities, symmetric) <input type="checkbox"/> Eyes (PERRL, EOMI, + RR, cover test, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> Ears (Canals clear, TMs normal, orients to sounds, voice) <input type="checkbox"/> Nose (Mucosa NL, septum NL, patent) <input type="checkbox"/> Mouth/Throat (MMM, palate intact, lips NL, tongue NL, no oral lesions, no erythema) <input type="checkbox"/> Teeth (Gums NL, dentition NL, no staining, caries or white spots)					<input type="checkbox"/> Heart (No murmurs, + femoral pulses) <input type="checkbox"/> Lungs (Clear breath sounds) <input type="checkbox"/> Abdomen (Soft, non-tender) <input type="checkbox"/> Skin (No rashes, no lesions) <input type="checkbox"/> Neuro (Tone, symmetry, strength, & gait NL) <input type="checkbox"/> Extremities (Full ROM, strength/tone NL, no hip dysplasia) <input type="checkbox"/> Genitalia <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge)		
Assessment				Anticipatory Guidance			
<input type="checkbox"/> Well child <input type="checkbox"/> Normal growth and development <input type="checkbox"/> IMMS UTD <input type="checkbox"/> IMMS due _____				<input type="checkbox"/> Discipline (Limit "no", use descriptors, temper tantrums, praise positive behavior, domestic violence) <input type="checkbox"/> Safety (Back to sleep, car seats, avoid smoke exposure, crib safety, burns, baby-proof home, drowning, poisoning, baby gates, supervise) <input type="checkbox"/> Nutrition (Self-feeding, family meals, avoid struggle over foods, healthy snacks, limit juice, use of cup, clean gums/brush teeth) <input type="checkbox"/> Development (Sleep routine, stranger anxiety, temperament, communication, read/play with baby, exploration and physical activity)			
Plan							
<input type="checkbox"/> Lead screening #1 (If not previously done) <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Education handout given <input type="checkbox"/> Immunizations (See immunization record)							

Next Appointment: _____ Signature: _____ Date: _____

