

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Current Medications			Drug / Food Allergies			Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	BMI and %ile	HC	HR	Temp.	Interpreter: Y / N	
Past Medical History			Interval History			Nutrition		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ Child has dental home: <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 Elimination: <input type="checkbox"/> NL _____ Behavior: <input type="checkbox"/> NL _____ Play time >60 mins/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Screen time <2hr/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			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 _____				<input type="checkbox"/> Autism-specific screening: <input type="checkbox"/> NL Tool _____ Cognitive: <input type="checkbox"/> NL _____ Language: <input type="checkbox"/> NL _____ • Names 1 picture (dog, ball, etc.); follows 2-step command • Uses 2 word phrases; asks parent to read book; >50 word vocabulary Physical: <input type="checkbox"/> NL _____ Social: <input type="checkbox"/> NL _____ • Stacks 5-6 blocks; can turn book pages one at a time • Parallel play; ↑ pretend play; refers to self as "I" or "me"				
Parental concerns: _____								
Physical Exam (checked <input type="checkbox"/> = normal)						Abnormal Findings		
<input type="checkbox"/> <b>General</b> (Alert, NAD, socialization NL) <input type="checkbox"/> <b>Head</b> (No deformities, symmetric) <input type="checkbox"/> <b>Eyes</b> (PERRL, EOMI, + RR, cover test, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> <b>Ears</b> (Canals clear, TMs normal, orients to sounds, voice) <input type="checkbox"/> <b>Nose</b> (Mucosa NL, septum NL, patent) <input type="checkbox"/> <b>Mouth/Throat</b> (MMM, palate intact, lips & tongue NL, no oral lesions, no erythema) <input type="checkbox"/> <b>Teeth</b> (Gums NL, dentition NL, no staining, caries or white spots)						<input type="checkbox"/> <b>Heart</b> (No murmurs, femoral pulses) <input type="checkbox"/> <b>Lungs</b> (Clear breath sounds) <input type="checkbox"/> <b>Abdomen</b> (Soft, non-tender) <input type="checkbox"/> <b>Skin</b> (No rashes, no lesions) <input type="checkbox"/> <b>Neuro</b> (Tone, symmetry, strength & gait NL) <input type="checkbox"/> <b>Extremities</b> (Full ROM, strength/tone NL, no hip dysplasia) <input type="checkbox"/> <b>Genitalia</b> <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"/> <b>Behavior</b> (Consistent discipline, temper tantrums, encourage play with other children, self-expression) <input type="checkbox"/> <b>Safety</b> (Bike helmet, car seats, second hand smoke, burns, smoke detectors, drowning, poisoning, supervise) <input type="checkbox"/> <b>Health Promotion</b> (Family meals, healthy snacks, limit juice, brush teeth, hand washing, daily physical activity, limit TV/screen time) <input type="checkbox"/> <b>Development</b> (Toilet training, playtime, follow 1-2 step commands, read every day, model language, listen and respond to child, sing)				
Plan								
<input type="checkbox"/> Autism-specific screening <input type="checkbox"/> Lead screening #2 <input type="checkbox"/> Dental fluoride varnish every 3-6 mos. either primary care or dental office <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> TB testing based on risk factors <input type="checkbox"/> Iron Deficiency Anemia risk assessment					<input type="checkbox"/> Dyslipidemia risk assessment <input type="checkbox"/> Education handout given <input type="checkbox"/> Immunizations (See immunization record)			

Next Appointment: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notes:**

[illegible]

**Next Appointment:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_