

Name: _____ DOB: _____ Date: _____

Current Medications		Drug / Food Allergies		Accompanied By	
Age □ M □ F	Ht.	Wt.	BMI and %ile	HR	Temp.
Past Medical History		Interval History		Nutrition	
Recent illness: □ Yes □ No _____ Child has dental home: □ Yes □ No _____ F/u previous concern: □ None _____		Sleep: □ NL _____ □ Bedtime routine Elimination: □ NL _____ Toilet training: □ Yes □ No Behavior: □ NL _____ Play time >60 mins/day: □ Yes □ No _____ Screen time <2hr/day: □ Yes □ No _____		□ Milk: _____ # oz/day: _____ Fruits: □ Yes □ No _____ Vegetables: □ Yes □ No _____ Meats: □ Yes □ No _____ Vitamins: □ Yes □ No Healthy snacks: □ Yes □ No Juice: □ Yes □ No Concerns: _____	
Social / Family History			Growth-Development		
Lives at home with: _____ Parent/ child interaction: □ Yes □ No _____ Tobacco smoke exposure: □ Yes □ No _____ Parents working outside home: □ Mother □ Father Child care: □ Yes □ No Type: _____ Family / work balance: □ Yes □ No _____ Recent family stressors: □ Yes □ No _____ WIC: □ Yes □ No _____			□ Structured developmental screening: □ NL Tool _____ Cognitive: □ NL _____ • Answers "where" questions; combines nouns & verbs "mommy go" Physical: □ NL _____ • Throws ball overhand; copies a vertical line; washes & dries hands. Language: □ NL _____ • Uses 3-4 word phrases; others can understand 50% of child's language Social: □ NL _____ • Imaginary play; plays with other children (tag, tea parties, etc.)		
Parental concerns: _____ _____ _____					
Physical Exam (checked □ = normal)				Abnormal Findings	
<input type="checkbox"/> General (Alert, NAD, socialization NL) <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, patent) <input type="checkbox"/> Mouth/Throat (MMM, palate intact, lips & 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/uncirc, 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"/> Behavior (Consistent discipline, temper tantrums, encourage play with other children, emerging independence) <input type="checkbox"/> Safety (Bike helmet, car seats, second hand smoke, burns, smoke detectors, drowning, poisoning, supervise, approaching new dogs) <input type="checkbox"/> Health Promotion (Family meals, healthy snacks, limit juice, brush teeth, hand washing, daily physical activity, limit TV/screen time) <input type="checkbox"/> Development (Toilet training, playtime with other children, preschool, language: read every day, model language, listen and respond to child, sing)			
Plan					
<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"/> Lead screening #2 (If Lead screening #2 not completed at 24 mos. visit) <input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Education handout given					

Next Appointment: _____ Signature: _____ Date: _____

Name: _____ **DOB:** _____ **Date:** _____

Notes:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Next Appointment: _____ **Signature:** _____ **Date:** _____