

Name: _____ DOB: _____ Date: _____

Current Medications		Drug / Food Allergies			Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	BMI and %ile	B/P	HR	Temp.	Interpreter: Y / N
Past Medical History		Interval History			Nutrition		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____		Sleep: <input type="checkbox"/> NL _____ Elimination: <input type="checkbox"/> NL _____ Toilet training: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Behavior: <input type="checkbox"/> NL _____ Play time >60 mins/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Activities / sports: _____ Screen time <2hr/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			Appetite: <input type="checkbox"/> NL _____ Fruits / vegetables: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Milk / calcium: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ↓ sugary drinks: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Snack habits: <input type="checkbox"/> NL _____ Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		
Child has dental home: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		Vision concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Hearing concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ F/u previous concern: <input type="checkbox"/> None _____					
Social / Family History				Growth-Development			
Lives at home with: _____ Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Parent / child interaction: <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 _____ • Identifies self as girl/boy; names 3-4 colors; draws person with 3 parts Physical: <input type="checkbox"/> NL _____ • Copies a circle/cross; rides tricycle; walks up stairs alternating feet Preschool: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Language: <input type="checkbox"/> NL _____ • Clear speech; sentences; gives first & last name; sings a song Social: <input type="checkbox"/> NL _____ • Self-care skills (dresses self, etc.) imaginary play; listens to stories			
Parental Concerns: _____ _____							
Physical Exam (checked <input type="checkbox"/> = 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, 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, no 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, no masses) <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) <input type="checkbox"/> Genitalia <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge) Tanner Stage: _____					
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, encourage play with other children, encourage fantasy play, emerging independence) <input type="checkbox"/> Safety (Bike helmet, playground and stranger safety, avoid second hand smoke) <input type="checkbox"/> Health Promotion (Family meals, nutrition, brush teeth, hand washing, daily physical activity, family exercise activities, limit TV/screen time) <input type="checkbox"/> Development (Toilet training, playtime with other children, preschool, language: read every day, listen and respond to child, sing songs together)			
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"/> TB testing based on risk factors <input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Dyslipidemia risk assessment (4 yo) <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Education handout given				<input type="checkbox"/> Hearing screen: <input type="checkbox"/> NL _____ (4 yo) <input type="checkbox"/> Lead screening #2 (If Lead screening #2 not completed at 24 mos. or 30 mos. visit) <input type="checkbox"/> Vision acuity: R___/___ L___/___ Both___/___ (3 yo and 4 yo)			

Next Appointment: _____ Signature: _____ Date: _____

