

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

<b>Current Medications</b>		<b>Drug / Food Allergies</b>			<b>Accompanied By</b>		
<b>Age</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Ht.</b>	<b>Wt.</b>	<b>HC</b>	<b>HR</b>	<b>Resp.</b>	<b>Temp.</b>	<b>Interpreter: Y / N</b>
<b>Past Medical History</b>		<b>Interval History</b>			<b>Nutrition</b>		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		Sleep: <input type="checkbox"/> NL _____ <input type="checkbox"/> Back to sleep <input type="checkbox"/> Sleeps in own crib			<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Supplementing / both		
Reaction to previous IMMS: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		Elimination: <input type="checkbox"/> NL _____			<input type="checkbox"/> Formula (type): _____		
F/u previous concern: <input type="checkbox"/> None _____		Behavior: <input type="checkbox"/> NL _____			Frequency: _____		
		Car seat rear-facing: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			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__		
					Concerns: _____		
<b>Social / Family History</b>				<b>Growth-Development</b>			
Lives at home with: _____				<input type="checkbox"/> Structured developmental screening: <input type="checkbox"/> NL Tool _____			
Parent / child interaction: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				Cognitive: <input type="checkbox"/> NL _____			
Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				• Object permanence, looks at books, knows "Peek-a-boo"			
Parents working outside home: <input type="checkbox"/> Mother <input type="checkbox"/> Father				Language: <input type="checkbox"/> NL _____			
Child care: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____				• Repetitive consonants & vowels, beginning to point out objects			
Family / work balance: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				Physical: <input type="checkbox"/> NL _____			
WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				• Crawling, pulls to standing			
				Social: <input type="checkbox"/> NL _____			
				• Apprehensive with strangers, seeks parent for play & comfort			
<b>Parental concerns:</b> _____							
_____							
_____							
<b>Physical Exam (checked <input type="checkbox"/> = normal)</b>					<b>Abnormal Findings</b>		
<input type="checkbox"/> <b>General</b> (Alert, NAD)		<input type="checkbox"/> <b>Heart</b> (No murmurs, + femoral pulses)					
<input type="checkbox"/> <b>Head</b> (No deformities, symmetric)		<input type="checkbox"/> <b>Lungs</b> (Clear breath sounds)					
<input type="checkbox"/> <b>Eyes</b> (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear)		<input type="checkbox"/> <b>Abdomen</b> (Soft, non-tender)					
<input type="checkbox"/> <b>Ears</b> (Canals clear, TMs normal, orients to sound, voice)		<input type="checkbox"/> <b>Skin</b> (No rashes)					
<input type="checkbox"/> <b>Nose</b> (mucosa NL, septum NL patent)		<input type="checkbox"/> <b>Neuro</b> (Tone, symmetry, strength all normal)					
<input type="checkbox"/> <b>Mouth</b> (MMM, palate intact, lips NL tongue NL, no oral lesions, teeth: __)		<input type="checkbox"/> <b>Extremities</b> (Full ROM, no hip dysplasia, tone/strength NL)					
<input type="checkbox"/> <b>Throat</b> (No erythema)		<input type="checkbox"/> <b>Genitalia</b> <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge)					
<b>Assessment</b>				<b>Anticipatory Guidance</b>			
<input type="checkbox"/> Well child				<input type="checkbox"/> <b>Discipline</b> (Limit "no", use descriptors, lead by example, domestic violence)			
<input type="checkbox"/> Normal growth and development				<input type="checkbox"/> <b>Safety</b> (Back to sleep, car seats, avoid smoke exposure, crib safety, burns, baby-proof home, drowning, poisoning, baby gates)			
<input type="checkbox"/> IMMS UTD				<input type="checkbox"/> <b>Nutrition</b> (Self-feeding, mealtime routines, table foods, use of cup)			
<input type="checkbox"/> IMMs due _____				<input type="checkbox"/> <b>Oral Health</b> (Fluoride, wash gums with warm washcloth, teething)			
				<input type="checkbox"/> <b>Development</b> (Sleep schedule, object permanence, separation anxiety, temperament, communication, read to baby visual exploration)			
<b>Plan</b>							
<input type="checkbox"/> Lead screening #1, if high risk (9 mos.)							
<input type="checkbox"/> Dental risk assessment (9 mos.)							
<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"/> Iron Deficiency Anemia risk assessment							
<input type="checkbox"/> Immunizations (See immunization record)							
<input type="checkbox"/> Education handout given							

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

