

ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE	DATE/TIME	Name		
DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER		
WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	BIRTH DATE	AGE
See growth chart.						M F

History

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☐ Term or _____ weeks	Blood type: Maternal _____
Birth weight _____	Infant _____ Direct Coombs _____
Discharge weight _____	Bilirubin screening ☐ None
Newborn hearing screening	Transcutaneous bilirubin _____
☐ Done & NL _____	Serum bilirubin _____
	Hep B (maternal): ☐ Pos ☐ Neg ☐ Unk
	Hep B vaccine _____ / _____ / _____

Concerns and questions ☐ None ☐ Addressed (see other side)

Follow-up on previous concerns ☐ None ☐ Addressed (see other side)

☐ Medication Record reviewed and updated

☐ Child has special health care needs ☐ Previsit Questionnaire reviewed

Social/Family History

See Initial History Questionnaire.

Family situation

Parent adjustment to new child _____

Maternal depression ☐ Y ☐ N _____

Reaction of siblings to new child _____

Work plans _____

Child care plans _____

Review of Systems

See Initial History Questionnaire and Problem List.

Changes since last visit _____

Nutrition: ☐ Breast milk Minutes per feeding _____

Hours between feeding _____ Feedings per 24 hours _____

Problems with breastfeeding _____

☐ Formula Ounces per feeding _____

Source of water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____

Sleep: ☐ NL _____

Behavior: ☐ NL _____

Development (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL ☐ COMMUNICATIVE ☐ PHYSICAL DEVELOPMENT

• Eats well • Turns and calms to your voice • Can suck, swallow, and breathe easily

☐ COGNITIVE • Follows your face

Physical Examination

☒ = NL Bright Futures Priority ☐ HEAD/FONTANELLE ☐ EYES (red reflex/strabismus/appears to see) ☐ HEART ☐ FEMORAL PULSES ☐ ABDOMEN (umbilical cord, vessels) ☐ SKIN (rashes, jaundice) ☐ NEUROLOGIC (tone, symmetry, state regulation) ☐ MUSCULOSKELETAL (torticollis) ☐ HIPS	Additional Systems ☐ GENERAL APPEARANCE ☐ EARS/APPEARS TO HEAR ☐ NOSE ☐ MOUTH AND THROAT ☐ LUNGS ☐ GENITALIA ☐ Male/Testes down ☐ Female ☐ EXTREMITIES ☐ BACK
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Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given ☐ NEWBORN TRANSITION • Back to sleep • Daily routines • Calming techniques ☐ NEWBORN CARE • Emergency preparedness plan • Frequent hand washing • Avoid direct sun exposure • Expect 6–8 wet diapers/day	☐ NUTRITIONAL ADEQUACY • Breastfeeding (vitamin D supplement) • Iron-fortified formula (if not breastfed) • No solid foods • No honey ☐ PARENTAL WELL-BEING • Baby blues • Accept help • Sleep when baby sleeps • Unwanted advice	☐ SAFETY • Car safety seat • Smoke-free environment • No shaking • Burns ◦ Water heater • Smoke detectors • Crib safety
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Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side



**This American Academy of Pediatrics Visit Documentation Form is consistent with
*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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