

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

☐ Previsit Questionnaire reviewed ☐ Child has special health care needs	Newborn screening ☐ NL Hearing screening ☐ NL
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Concerns and questions ☐ None ☐ Addressed (see other side)

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

Interval history ☐ None ☐ Addressed (see other side)

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Family situation

Parental adjustment to child _____

Maternal depression ☐ Y ☐ N _____

Parents working outside home: ☐ Mother ☐ Father

Child care: ☐ Yes ☐ No Type _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

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)

☐ PHYSICAL DEVELOPMENT	☐ COGNITIVE	☐ SOCIAL-EMOTIONAL
• Lifts head and begins to push up when prone • Holds head erect for short periods (when held upright) • Diminished newborn reflexes • Symmetrical movement	• Indicates boredom when no activity change ☐ COMMUNICATIVE • Coos • Different cries for different needs	• Smiles • Looks at parent • Self-comfort

Physical Examination

☒ = NL

Bright Futures Priority

☐ SKIN (rashes, bruising)

☐ HEAD/FONTANELLE (positional skull deformities)

☐ EYES (red reflex/strabismus/ appears to see)

☐ HEART

☐ FEMORAL PULSES

☐ MUSCULOSKELETAL (torticollis)

☐ HIPS

☐ NEUROLOGIC (tone, strength, symmetry)

Additional Systems

☐ GENERAL APPEARANCE	☐ GENITALIA
☐ EARS/APPEARS TO HEAR	☐ Male/Testes down
☐ NOSE	☐ Female
☐ MOUTH AND THROAT	☐ EXTREMITIES
☐ LUNGS	☐ BACK
☐ ABDOMEN	

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given	☐ PARENTAL (MATERNAL) WELL-BEING	☐ INFANT BEHAVIOR	☐ SAFETY
☐ INFANT-FAMILY SYNCHRONY	☐ NUTRITIONAL ADEQUACY	• Calming skills • Physical • Tummy time • Daily routines • Sleep • Back to sleep	• Car safety seat • Falls • Burns • Hot liquids • Water heater • Smoke-free environment • Drowning • Choking • Small objects • Plastic bags
• Breastfeeding (400 IU vitamin D supplement) • Iron-fortified formula • Solid foods (wait until 4–6 months) • Elimination • No bottle in bed			

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

American Academy of Pediatrics

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**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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