

|                          |            |                       |               |             |            |     |
|--------------------------|------------|-----------------------|---------------|-------------|------------|-----|
| 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

|                                                                                                                  |                                                              |
|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Previsit Questionnaire reviewed                                                         | <input type="checkbox"/> Child has special health care needs |
| Concerns and questions <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side)         |                                                              |
| Follow-up on previous concerns <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side) |                                                              |
| Interval history <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side)               |                                                              |
| <input type="checkbox"/> Medication Record reviewed and updated                                                  |                                                              |

## Social/Family History

See Initial History Questionnaire. ☐ No interval change

**Family situation**

Parental support—work/family balance \_\_\_\_\_

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 \_\_\_\_\_

Activity (tummy time, no TV): ☐ NL \_\_\_\_\_

### Development (if not reviewed in Previsit Questionnaire)

|                                                                                                                                                      |                                                                                                                                                                                                      |                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> PHYSICAL DEVELOPMENT <ul style="list-style-type: none"><li>Sits briefly, leaning forward</li><li>Rolls over</li></ul>       | <input type="checkbox"/> COMMUNICATIVE <ul style="list-style-type: none"><li>Uses a string of vowels (ah, eh, oh)</li><li>Beginning to recognize own name</li><li>Enjoys vocal turn taking</li></ul> | <input type="checkbox"/> SOCIAL-EMOTIONAL <ul style="list-style-type: none"><li>Shows pleasure from interactions with parents or others</li></ul> |
| <input type="checkbox"/> COGNITIVE <ul style="list-style-type: none"><li>Uses visual exploration</li><li>Beginning to use oral exploration</li></ul> |                                                                                                                                                                                                      |                                                                                                                                                   |

## Physical Examination

☒ NL

**Bright Futures Priority**

- ☐ SKIN (rashes, bruising)
- ☐ EYES (red reflex/strabismus/ appears to see)
- ☐ HEART
- ☐ FEMORAL PULSES
- ☐ MUSCULOSKELETAL (torticollis)
- ☐ HIPS
- ☐ NEUROLOGIC (tone, strength, symmetry)

**Additional Systems**

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

Abnormal findings and comments \_\_\_\_\_

## Assessment

☐ Well child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Anticipatory Guidance

☐ Discussed and/or handout given

|                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> FAMILY FUNCTIONING                                                                                                                                                                                                                                                         | <input type="checkbox"/> INFANT DEVELOPMENT                                                                                                                                                                                                | <input type="checkbox"/> SAFETY                                                                                                                                                                                                                                    |
| <input type="checkbox"/> NUTRITION AND FEEDING <ul style="list-style-type: none"><li>Breastfeeding (vitamin D, iron supplement)</li><li>Iron-fortified formula</li><li>Solid foods<ul style="list-style-type: none"><li>Types and amounts</li><li>Begin cup</li><li>Elimination</li></ul></li></ul> | <ul style="list-style-type: none"><li>Social development</li><li>Communication skills</li><li>Sleep</li></ul> <input type="checkbox"/> ORAL HEALTH <ul style="list-style-type: none"><li>Brush teeth</li><li>Avoid bottle in bed</li></ul> | <ul style="list-style-type: none"><li>Car safety seat</li><li>Poisons</li><li>Burns<ul style="list-style-type: none"><li>Hot water</li></ul></li><li>Falls</li><li>Infant walkers</li><li>Drowning</li><li>Choking (finger foods)</li><li>Kitchen safety</li></ul> |

## Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results \_\_\_\_\_

☐ Referral to \_\_\_\_\_

**Follow-up/Next visit** \_\_\_\_\_

☐ See other side

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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