

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
☐ Child has a dental home	

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

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 _____
☐ Formula Ounces per feeding _____
Source of water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____

Sleep: ☐ NL _____

Behavior: ☐ NL _____

Activity (playtime, no TV): ☐ NL _____

Development (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL • Waves bye-bye • Tries to do what you do • Cries when you leave • Plays peekaboo • Hands you a book to read	☐ COMMUNICATIVE • Speaks 1-2 words • Babbles • Tries to make the same sounds you do • Looks at things you are looking at ☐ COGNITIVE • Follows simple directions	☐ PHYSICAL DEVELOPMENT • Bangs toys together • Pulls to stand • Stands alone • Drinks from a cup
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Physical Examination

☒ = NL

Bright Futures Priority

- ☐ EYES (red reflex, cover/uncover test)
- ☐ NEUROLOGIC (tone, strength, gait)
- ☐ TEETH (caries, white spots, staining)
- ☐ GENITALIA
 - ☐ MALE/TESTES DOWN
 - ☐ FEMALE

Additional Systems

- ☐ GENERAL APPEARANCE
- ☐ HEAD/FONTANELLE
- ☐ EARS/APPEARS TO HEAR
- ☐ NOSE
- ☐ MOUTH AND THROAT
- ☐ HEART
 - ☐ Femoral pulses
- ☐ EXTREMITIES/HIPS
- ☐ LUNGS
- ☐ ABDOMEN
- ☐ BACK
- ☐ SKIN

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY SUPPORT • Time for self/partner • Community activities • Age-appropriate discipline ☐ ESTABLISHING ROUTINES • Family traditions • Nap and bedtime	☐ FEEDING AND APPETITE CHANGES • Self-feeding • Consistent meals/snacks • Variety of nutritious foods • Iron-fortified formula ☐ ESTABLISHING A DENTAL HOME • First dentist visit • Brush teeth twice a day • Limit bottle use (water only) • No bottle in bed	☐ SAFETY • Car safety seat • Poisons • Water • No supervision by young children • Sharp objects • Guns • Home safety • Falls
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Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Hgb/Hct ☐ Lead ☐ Other _____

☐ 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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