

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 ☐ Bottle ☐ Cup

Milk _____ Ounces per day _____

Solid foods _____

Juice _____

Source of water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____

Sleep: ☐ NL _____

Behavior: ☐ NL _____

Activity (playtime, no TV): ☐ NL _____

Development

☐ Structured developmental screen ☐ NL Tool _____

☐ Autism-specific screen ☐ NL Tool _____

Developmental Surveillance (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL	☐ COMMUNICATIVE	☐ PHYSICAL DEVELOPMENT
• Helps in the house	• Speaks 6 words	• Stacks 2 small blocks
• Laughs in response to others	☐ COGNITIVE	• Runs
	• Knows name of favorite book	• Walks up steps
	• Points to 1 body part	• Uses spoon and cup without spilling most of the time

Physical Examination

☒ = NL

Bright Futures Priority

☐ EYES (red reflex, cover/uncover test)

☐ SKIN (nevi, café au lait, bruising)

☐ NEUROLOGIC (gait, coordination)

☐ TEETH (caries, white spots, staining)

Additional Systems

☐ GENERAL APPEARANCE

☐ HEAD/FONTANELLE

☐ EARS/APPEARS TO HEAR

☐ NOSE

☐ LUNGS

☐ MOUTH AND THROAT

☐ HEART

☐ Femoral pulses

☐ ABDOMEN

☐ GENITALIA

☐ Male/Testes down

☐ Female

☐ EXTREMITIES/HIPS

☐ BACK

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY SUPPORT

- Family time
- Time for self and other children
- Reinforce limits
- Prepare for new sibling (if necessary)
- Smoke-free environment

☐ CHILD DEVELOPMENT AND BEHAVIOR

- Anticipate anxiety
- Praise
- Consistent discipline
- Daily playtime

☐ LANGUAGE PROMOTION/HEARING

- Read, talk, and sing
- Simple words
- Feelings and emotions

☐ TOILET TRAINING READINESS

- Wait until child is ready
- Reading books/praise

☐ SAFETY

- Car safety seat
- Falls
- Burns
- Smoke detectors
- Guns
- Poisons

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

DEDICATED TO THE HEALTH OF ALL CHILDREN™



**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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