

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 _____

Observation of parent-child interaction _____

Reaction of siblings to new child _____

Work plans _____

Child care plans _____

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)

☐ SOCIAL-EMOTIONAL	☐ COMMUNICATIVE	☐ PHYSICAL DEVELOPMENT
• If upset, able to calm	• Recognizes parents' voices	• Able to lift head when on tummy
☐ COGNITIVE	• Follows parent with eyes	
• Has started to smile		

Physical Examination

☒ = NL

Bright Futures Priority

☐ HEAD/FONTANELLE (positional skull deformities) ☐ EYES (red reflex/strabismus/ appears to see) ☐ HEART ☐ FEMORAL PULSES ☐ ABDOMEN ☐ MUSCULOSKELETAL (torticollis) ☐ HIPS ☐ NEUROLOGIC (tone, strength, symmetry)	Additional Systems ☐ GENERAL APPEARANCE ☐ EARS/APPEARS TO HEAR ☐ NOSE ☐ MOUTH AND THROAT ☐ LUNGS ☐ GENITALIA ☐ Male/Testes down ☐ Female	☐ EXTREMITIES ☐ BACK ☐ SKIN
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Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ PARENTAL WELL-BEING ☐ FAMILY ADJUSTMENT ☐ FEEDING ROUTINES • Breastfeeding (400 IU vitamin D supplement) • Iron-fortified formula • Solid foods (wait until 4–6 months) • Elimination ◦ 5–8 wet diapers, 3–4 stools	☐ INFANT ADJUSTMENT • Tummy time • Encourage daily routines • Back to sleep • Sleep location • Techniques to calm	☐ SAFETY • Car safety seat • Falls • No strings around neck • No shaking • Smoke-free environment
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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	



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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	

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DRUG ALLERGIES			CURRENT MEDICATIONS		ID NUMBER		
WEIGHT (%)	HEIGHT (%)	HEAD CIRC (%)	BMI (%)	TEMPERATURE	BIRTH DATE	AGE	M F

See growth chart.

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 _____

Elimination: ☐ NL _____

Toilet training: ☐ Yes ☐ In process _____

Sleep: ☐ NL _____

Behavior/Temperament: ☐ NL _____

Physical activity

Play time (60 min/d) ☐ Yes ☐ No

Screen time (<2 h/d) ☐ Yes ☐ No

Development

☐ Structured developmental screen ☐ NL Tool _____

Developmental Surveillance (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL	☐ COMMUNICATIVE	☐ PHYSICAL DEVELOPMENT
• Plays pretend	• Other people can understand what your child is saying half of the time	• Jumps up and down in place
• Plays with other children (eg, tag)	• When talking, puts 3 or 4 words together	• Puts on clothes with help
		• Washes and dries hands without help
		• Brushes teeth with help
	☐ COGNITIVE	
	• Points to 6 body parts	
	• Knows correct animal sounds (eg, cat meows, dog barks)	

Physical Examination

☒ = NL

Bright Futures Priority

☐ EYES (red reflex, cover/uncover test)

☐ NEUROLOGIC (coordination, language, socialization)

Additional Systems

☐ GENERAL APPEARANCE	☐ LUNGS
☐ HEAD	☐ HEART
☐ EARS	☐ ABDOMEN
☐ NOSE	☐ GENITALIA
☐ MOUTH AND THROAT	☐ Male/Testes down
☐ NECK	☐ Female
☐ TEETH	☐ EXTREMITIES/HIPS
	☐ BACK
	☐ SKIN

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY ROUTINES	☐ SOCIAL DEVELOPMENT	☐ SAFETY
• Family meals	• Supervised play with other children	• Car safety seat
• Family activities	• Setting limits	• Water
☐ LANGUAGE PROMOTION AND COMMUNICATION	• Emerging independence	• Appropriate supervision
• Limit TV	☐ PRESCHOOL CONSIDERATIONS	• Sun exposure
• Daily reading	• Group activities/ preschool (if possible)	• Fire safety
• Listen and repeat to child	• Toilet training	• Smoke detectors
		• Outdoor safety
		• Playground
		• Dogs

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

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See growth chart.						M F

History

H O S P I T A L	☐ 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

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

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

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	

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DRUG ALLERGIES			CURRENT MEDICATIONS		ID NUMBER		
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE		TEMPERATURE	BIRTH DATE	AGE

See growth chart.

History				Physical Examination			
☐ Previsit Questionnaire reviewed ☐ Child has a dental home		☐ Child has special health care needs		☒ = NL Bright Futures Priority ☐ EYES (red reflex, cover/uncover test) ☐ TEETH (caries, white spots, staining) ☐ NEUROLOGIC (language, speech, social interaction)			
Concerns and questions ☐ None ☐ Addressed (see other side)				Additional Systems ☐ GENERAL APPEARANCE ☐ LUNGS ☐ HEAD ☐ HEART ☐ EARS ☐ ABDOMEN ☐ NOSE ☐ GENITALIA ☐ MOUTH AND THROAT ☐ EXTREMITIES ☐ NECK ☐ BACK ☐ SKIN			
Follow-up on previous concerns ☐ None ☐ Addressed (see other side)				Abnormal findings and comments _____			
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 _____

Preschool: ☐ Yes ☐ No

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit _____

Nutrition _____

Elimination: ☐ NL _____

Toilet training: ☐ Yes ☐ In process _____

Sleep: ☐ NL _____

Behavior/Temperament: ☐ NL _____

Physical activity

 Play time (60 min/d) ☐ Yes ☐ No

 Screen time (<2 h/d) ☐ Yes ☐ No

Parent-child interaction

 Communication: ☐ NL _____

 Choices: ☐ NL _____

 Cooperation: ☐ NL _____

 Appropriate responses to behavior: ☐ NL _____

Development (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL • Self-care skills • Imaginative play	☐ COMMUNICATIVE • 2–3 sentences • Usually understandable • Names a friend ☐ COGNITIVE • Names objects • Knows if boy or girl	☐ PHYSICAL DEVELOPMENT • Builds tower (6–8 blocks) • Stands on 1 foot • Throws ball overhand • Walks upstairs alternating feet • Copies circle • Draws person (2 body parts) • Toilet trained during day
--	--	---

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY SUPPORT • Show affection • Manage anger • Reinforce appropriate behavior • Reinforce limits • Find time for yourself	☐ PLAYING WITH PEERS • Encourage appropriate play • Encourage fantasy play • Encourage play with peers ☐ PROMOTING PHYSICAL ACTIVITY • Family exercise, activities • Limit screen time—maximum 1–2 hours/day • No TV in bedroom	☐ SAFETY • Car safety seat • Supervise play near streets, cars • Safety near windows • Guns
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☐ **ENCOURAGING LITERACY ACTIVITIES**
 • Read, sing, play
 • Talk about pictures in books
 • Encourage child to talk

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ **Vision** _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
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				AGE	

See growth chart.

M F

History

☐ Previsit Questionnaire reviewed	☐ Child has special health care needs
--	--

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 support—work/family balance

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): ☐ NL

Development (if not reviewed in Previsit Questionnaire)

☐ PHYSICAL DEVELOPMENT • Pushes chest up to elbows • Good head control • Symmetry in movements • Begins to roll and reach for objects	☐ COGNITIVE • Responds to affection • Indicates pleasure and displeasure ☐ COMMUNICATIVE • Spontaneous expressive babbling	☐ SOCIAL-EMOTIONAL • Social smile • Elicits social interactions • Can calm down on own
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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
☐ LUNGS	☐ Male/Testes down
☐ EARS/APPEARS TO HEAR	☐ Female
☐ NOSE	☐ EXTREMITIES
☐ MOUTH AND THROAT	☐ BACK
☐ ABDOMEN	

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given	☐ INFANT DEVELOPMENT • Social development • Communication skills • Physical (tummy time) • Daily routines • Sleep	☐ SAFETY • Car safety seat • Burns • Hot liquids • Water heaters • Falls • Walkers • Choking • Drowning • Lead poisoning
☐ FAMILY FUNCTIONING	☐ ORAL HEALTH • Don't share utensils/pacifier • Avoid bottle in bed	
☐ NUTRITIONAL ADEQUACY AND GROWTH • Breastfeeding (vitamin D, iron supplement) • Iron-fortified formula • Solid foods ◦ When and how to add • Weight gain and growth spurts • Elimination		

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	

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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 _____

Preschool: ☐ Yes ☐ No _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit _____

Nutrition _____

Elimination: ☐ NL _____

Toilet trained: ☐ Yes ☐ No _____

Sleep: ☐ NL _____

Behavior/Temperament: ☐ NL _____

Physical activity

Play time (60 min/d) ☐ Yes ☐ No

Screen time (<2 h/d) ☐ Yes ☐ No

Toxic exposure: Passive smoking ☐ Yes ☐ No

Parent-child interaction

Communication: ☐ NL _____

Choices: ☐ NL _____

Cooperation: ☐ NL _____

Appropriate responses to behavior: ☐ NL _____

Development (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL • Interactions with peers • Fantasy play	☐ COGNITIVE • Names 4 colors • Draws person (3 body parts) • Plays board/card games	☐ PHYSICAL DEVELOPMENT • Hops on 1 foot • Balances on 1 foot for 2 seconds • Builds tower (8 blocks) • Copies a cross • Brushes own teeth • Dresses self
☐ COMMUNICATIVE • Usually understandable • Knows name, age, gender		

Physical Examination

☒ = NL

Bright Futures Priority

☐ **NEUROLOGIC**

☐ FINE MOTOR SKILLS

☐ GROSS MOTOR SKILLS

☐ LANGUAGE

☐ SPEECH

☐ THOUGHT PROCESS

☐ TEETH (caries, white spots, staining)

Additional Systems

☐ GENERAL APPEARANCE

☐ HEAD

☐ EARS

☐ NOSE

☐ MOUTH AND THROAT

☐ NECK

☐ LUNGS

☐ HEART

☐ ABDOMEN

☐ GENITALIA

☐ EXTREMITIES

☐ BACK

☐ SKIN

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ SCHOOL READINESS

- Model behavior
- Be sensitive to child's feelings
- Encourage play with other children
- Consider preschool
- Daily reading
- Talk with child

☐ TV/MEDIA

- Limit TV/video to 1–2 hours/day
- No TV in bedroom

☐ CHILD AND FAMILY INVOLVEMENT

- Community activities
- Expect curiosity about body—answer questions using proper terms
- Safety rules with adults
- Good and bad touches
- How to seek help when needed

☐ SAFETY

- Appropriately restrained in all vehicles
- Supervise all outdoor play
- Guns

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Vision ☐ Hearing

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
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ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE	DATE/TIME	Name	
DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	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

After-school care: ☐ Yes ☐ No

Changes since last visit

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit

Nutrition

Sleep: ☐ NL

Physical activity

Play time (60 min/d) ☐ Yes ☐ No

Screen time (<2 h/d) ☐ Yes ☐ No

School: Grade Special education ☐ Yes ☐ No

Social interaction ☐ NL

Performance ☐ NL

Behavior ☐ NL

Attention ☐ NL

Homework ☐ NL

Parent/Teacher concerns ☐ None

Home: Parent-child-sibling interaction ☐ NL

Cooperation/Oppositional behavior ☐ NL

Development (if not reviewed in Previsit Questionnaire)

☐ MOTOR - Balances on 1 foot - Hops and skips - Able to tie knot	☐ LANGUAGE - Good articulation/language skills ☐ LEARNING - Draws person (6+ body parts) - Prints some letters and numbers - Copies squares, triangles	- Counts to 10 - Names 4 or more colors - Follows simple directions - Listens and attends
---	--	---

Physical Examination

☒ = NL

Bright Futures Priority

☐ EYES

☐ MOUTH/TEETH (caries, gingival)

☐ NEUROLOGIC (fine/gross motor)

☐ GAIT

☐ LANGUAGE

Additional Systems

☐ GENERAL APPEARANCE	☐ HEART
☐ HEAD	☐ ABDOMEN
☐ EARS	☐ GENITALIA
☐ THROAT	☐ EXTREMITIES
☐ NOSE	☐ BACK
☐ NECK	☐ SKIN
☐ LUNGS	

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ SCHOOL READINESS - Establish routines - After-school care/activities - Friends - Bullying - Communicate with teachers	☐ NUTRITION AND PHYSICAL ACTIVITY - Healthy weight - Well-balanced diet, including breakfast - Fruits, vegetables, whole grains - Adequate calcium 60 minutes of exercise/day	☐ SAFETY - Sexual safety - Pedestrian safety - Safety helmets - Swimming safety - Fire escape plan - Smoke/carbon monoxide detectors - Guns - Sun - Appropriately restrained in all vehicles
☐ MENTAL HEALTH - Family time - Anger management - Discipline for teaching not punishment - Limit TV	☐ ORAL HEALTH - Regular dentist visits - Brushing/Flossing - Fluoride	

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Vision ☐ Hearing

☐ Referral to

Follow-up/Next visit

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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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
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 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)

☐ PHYSICAL DEVELOPMENT - Sits briefly, leaning forward - Rolls over	☐ COMMUNICATIVE - Uses a string of vowels (ah, eh, oh) - Beginning to recognize own name - Enjoys vocal turn taking	☐ SOCIAL-EMOTIONAL Shows pleasure from interactions with parents or others
☐ COGNITIVE - Uses visual exploration - Beginning to use oral exploration		

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

☐ FAMILY FUNCTIONING	☐ INFANT DEVELOPMENT	☐ SAFETY
☐ NUTRITION AND FEEDING - Breastfeeding (vitamin D, iron supplement) - Iron-fortified formula - Solid foods - Types and amounts - Begin cup - Elimination	- Social development - Communication skills - Sleep ☐ ORAL HEALTH - Brush teeth - Avoid bottle in bed	- Car safety seat - Poisons - Burns - Hot water - Falls - Infant walkers - Drowning - Choking (finger foods) - Kitchen safety

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

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DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE	AGE M F

See growth chart.

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

After-school care: ☐ Yes ☐ No

Changes since last visit

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit

Nutrition

Sleep: ☐ NL

Physical activity

Play time (60 min/d) ☐ Yes ☐ No

Screen time (<2 h/d) ☐ Yes ☐ No

School: Grade Special education ☐ Yes ☐ No

Social interaction ☐ NL

Performance ☐ NL

Behavior ☐ NL

Attention ☐ NL

Homework ☐ NL

Parent/Teacher concerns ☐ None

Home: Cooperation ☐ NL

Parent-child interaction ☐ NL

Sibling interaction ☐ NL

Oppositional behavior ☐ None

Development (if not reviewed in Previsit Questionnaire)

- Eats healthy meals and snacks
- Participates in an after-school activity
- Has friends
- Is vigorously active for 1 hour a day
- Is doing well in school
- Does chores when asked
- Gets along with family

Physical Examination

☒ = NL

Bright Futures Priority

☐ **MUSCULOSKELETAL** (hip, knee, ankle)

☐ **MOUTH/TEETH** (caries, gingival)

☐ **BREASTS/GENITALIA**

SEXUAL MATURITY RATING _____

Additional Systems

☐ GENERAL APPEARANCE

☐ NECK

☐ HEAD

☐ EYES

☐ EARS

☐ NOSE

☐ LUNGS

☐ THROAT

☐ HEART

☐ ABDOMEN

☐ BACK

☐ SKIN

☐ NEUROLOGIC

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ **SCHOOL**

- Show interest in school
- Communicate with teachers

☐ **DEVELOPMENT AND MENTAL HEALTH**

- Encourage independence
- Praise strengths
- Be a positive role model
- Discuss expected body changes

☐ **NUTRITION AND PHYSICAL ACTIVITY**

- Encourage proper nutrition
- Eat meals as a family
- 60 minutes of physical activity daily
- Limit TV and screen time

☐ **ORAL HEALTH**

- Dental visits twice a year
- Brush teeth twice a day
- Floss teeth daily
- Wear mouth guard during sports

☐ **SAFETY**

- Know child's friends
- Home emergency plan
- Safety rules with adults
- Appropriate vehicle restraint
- Helmets and pads
- Supervise around water
- Smoke-free environment
- Guns
- Monitor computer use

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ **Vision** ☐ **Hearing**

☐ Referral to

Follow-up/Next visit

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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				AGE	
				M F	

See growth chart.

History

☐ Previsit Questionnaire reviewed	☐ Child has special health care needs
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

☐ Structured developmental screen ☐ NL Tool _____

Developmental Surveillance (if not reviewed in Previsit Questionnaire)

☐ PHYSICAL DEVELOPMENT	☐ COGNITIVE	☐ SOCIAL-EMOTIONAL
• Sits well	• Peekaboo	• Stranger anxiety
• Crawls	• Object permanence	• Seeks parent for comfort
• Pulls to feet with support	• Looks at books	
	☐ COMMUNICATIVE	
	• Imitates sounds	
	• Points out objects	

Physical Examination

☒ = NL

Bright Futures Priority

☐ HEAD (positional skull deformities)

☐ EYES (ocular mobility, eye alignment, red reflex)

☐ HEART

☐ FEMORAL PULSES

☐ MUSCULOSKELETAL (torticollis)

☐ HIPS

☐ NEUROLOGIC (tone, strength, symmetry of movements, parachute reflex)

Additional Systems

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

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY ADAPTATIONS	☐ FEEDING ROUTINE	☐ SAFETY
• Limit word "no"	• Self-feeding	• Car safety seat
• Age-appropriate discipline	• Solid foods	• Poisons
• Domestic violence	• Safe foods	• Water/Drowning
• Time for self/partner	• Using a cup	• Falls/Window guards
☐ INFANT INDEPENDENCE	• Breastfeeding (vitamin D, iron supplement)	• Burns
• Consistent routines	• Iron-fortified formula	• Guns
• Separation anxiety	• No bottle in bed	
• Learning and developing	• Brush teeth	
• No TV		

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	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

After-school care: ☐ Yes ☐ No

Changes since last visit

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit

Nutrition

Physical activity

Play time (60 min/d) ☐ Yes ☐ No

Screen time (<2 h/d) ☐ Yes ☐ No

School: Grade

Social interaction ☐ NL

Performance ☐ NL

Behavior ☐ NL

Attention ☐ NL

Homework ☐ NL

Parent/Teacher concerns ☐ None

Home: Cooperation ☐ NL

Parent-child interaction ☐ NL

Sibling interaction ☐ NL

Oppositional behavior ☐ None

Development (if not reviewed in Previsit Questionnaire)

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Eats healthy meals and snacks ▪ Participates in an after-school activity ▪ Has friends ▪ Is vigorously active for 1 hour a day ▪ Has a caring/supportive family | <ul style="list-style-type: none"> ▪ Is doing well in school ▪ Is getting chances to make own decisions ▪ Feels good about self ▪ Does an activity really well; describe: |
|---|---|

Physical Examination

☑=NL

Bright Futures Priority

☐ SKIN (tattoos, piercing, bruising, nevi)

☐ BACK (scoliosis)

☐ BREASTS/GENITALIA

SEXUAL MATURITY

RATING

Additional Systems

☐ GENERAL APPEARANCE

☐ HEAD

☐ EYES

☐ EARS

☐ NOSE

☐ MOUTH, THROAT, TEETH

☐ NECK

☐ LUNGS

☐ HEART

☐ ABDOMEN

☐ SKIN

☐ EXTREMITIES

☐ NEUROLOGIC

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ SCHOOL

- Show interest in school
- Quiet space for homework
- Address bullying

☐ DEVELOPMENT AND MENTAL HEALTH

- Encouraging independence and self-responsibility
- Be a positive role model—discuss respect, anger
- Know child's friends and importance of peers

- Expect preadolescent behaviors
- Answer questions and discuss puberty
- Safety rules with adults

☐ NUTRITION AND PHYSICAL ACTIVITY

- Encourage proper nutrition
- 60 minutes of physical activity daily
- Limit TV and screen time

☐ ORAL HEALTH

- Dental visits twice a year
- Brush teeth twice a day
- Floss teeth daily
- Wear mouth guards during sports
- ☐ SAFETY
- Booster seat
- Teach to swim/water safety
- Sunscreen
- Avoid tobacco, alcohol, drugs
- Guns

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Vision ☐ Hearing

☐ Referral to

Follow-up/Next visit

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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DRUG ALLERGIES			CURRENT MEDICATIONS			ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE		BIRTH DATE		AGE M F

Visit with: ☐ Teen alone ☐ Parent(s) alone ☐ Mother ☐ Father ☐ Teen with parents ☐ Other _____

History

☐ Previsit Questionnaire reviewed	☐ Teen has special health care needs
☐ Teen 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)

Menarche: Age _____ Regularity _____

Menstrual problems _____

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Risk Assessment

If not reviewed in Supplemental Questionnaire
(Use other side if risks identified.)

HOME

Eats meals with family ☐ Yes ☐ No

Has family member/adult to turn to for help ☐ Yes ☐ No

Is permitted and is able to make independent decisions ☐ Yes ☐ No

EDUCATION

Grade _____

Performance ☐ NL _____

Behavior/Attention ☐ NL _____

Homework ☐ NL _____

EATING

Eats regular meals including adequate fruits and vegetables ☐ Yes ☐ No

Drinks non-sweetened liquids ☐ Yes ☐ No

Calcium source ☐ Yes ☐ No

Has concerns about body or appearance ☐ Yes ☐ No

ACTIVITIES

Has friends ☐ Yes ☐ No

At least 1 hour of physical activity/day ☐ Yes ☐ No

Screen time (except for homework) less than 2 hours/day ☐ Yes ☐ No

Has interests/participates in community activities/volunteers ☐ Yes ☐ No

DRUGS (Substance use/abuse)

Uses tobacco/alcohol/drugs ☐ Yes ☐ No

SAFETY

Home is free of violence ☐ Yes ☐ No

Uses safety belts/safety equipment ☐ Yes ☐ No

Has peer relationships free of violence ☐ Yes ☐ No

SEX

Has had oral sex ☐ Yes ☐ No

Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

SUICIDALITY/MENTAL HEALTH

Has ways to cope with stress ☐ Yes ☐ No

Displays self-confidence ☐ Yes ☐ No

Has problems with sleep ☐ Yes ☐ No

Gets depressed, anxious, or irritable/has mood swings ☐ Yes ☐ No

Has thought about hurting self or considered suicide ☐ Yes ☐ No

Physical Examination

☒ = NL

Bright Futures Priority

☐ **SKIN**

☐ **BACK/SPINE**

☐ **BREASTS**

☐ **GENITALIA**

SEXUAL MATURITY RATING _____

Additional Systems

☐ GENERAL APPEARANCE ☐ TEETH

☐ HEAD ☐ LUNGS

☐ EYES ☐ HEART

☐ EARS ☐ ABDOMEN

☐ NOSE ☐ EXTREMITIES

☐ MOUTH AND THROAT ☐ NEUROLOGIC

☐ NECK

Abnormal findings and comments _____

Assessment

☐ Well teen

Anticipatory Guidance

☐ Discussed and/or handout given

☐ **PHYSICAL GROWTH AND DEVELOPMENT**

- Brush/Floss teeth
- Regular dentist visits
- Body image
- Balanced diet
- Limit TV
- Physical activity

☐ **SOCIAL AND ACADEMIC COMPETENCE**

- Help with homework when needed
- Encourage reading/school
- Community involvement

- Family time
- Age-appropriate limits
- Friends

☐ **EMOTIONAL WELL-BEING**

- Decision-making
- Dealing with stress
- Mental health concerns
- Sexuality/Puberty

☐ **RISK REDUCTION**

- Tobacco, alcohol, drugs
- Prescription drugs
- Know friends and activities
- Sex

☐ **VIOLENCE AND INJURY PREVENTION**

- Seat belts, no ATV
- Guns
- Safe dating
- Conflict resolution
- Bullying
- Sport helmets
- Protective gear

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ **Vision**

☐ 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™

WELL CHILD/11 to 14 years

Psychosocial Risks
Confidential (To be completed confidentially for teens with identified risk)

Home
Relationship with parents/guardians
Violence in home
Teen's concerns
Autonomy
Counseling/Recommendations

Education
Teen's concerns
Social interactions
Conflicts
Counseling/Recommendations

Eating
Usual diet
Attempts to lose weight by dieting, laxatives, or self-induced vomiting
Regular meals (includes breakfast, limits fast food)
Counseling/Recommendations

Activities
Clubs/Extracurricular
Music/Art
Sports
Religious/Community
TV/Electronics hours/day
Gangs
Counseling/Recommendations

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G.
Validity of the CRAFFT substance abuse screening test among adolescent clinic patients.
Arch Pediatr Adolesc Med. 2002;156:607-614
HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. Contemp Pediatr. 2004;21:64-90
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Drugs (Substance Use/Abuse)
Tobacco use
Alcohol
Drugs (street/prescription)
Steroids
CRAFFT (+2 indicates need for follow-up)
C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A - Do you ever use alcohol or drugs while you are by yourself, ALONE?
F - Do you ever FORGET things you did while using alcohol or drugs?
F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T - Have you gotten into TROUBLE while you were using alcohol or drugs?
Counseling/Recommendations

Safety
Bullying
Guns
Dating violence
Passenger safety
Sports/recreation safety
Counseling/Recommendations

Sex
Oral sex
Has had sexual intercourse (vaginal, anal)
Age of onset of sexual activity
Number of partners
Gender of partners
Sexual orientation
Condom use
Contraception
Previous pregnancy
Previous STI
Laboratory/Screening results
Pregnancy test
Pap smear
Chlamydia/Gonorrhea, source
Syphilis
HIV
STI screening laboratory results (specify)
Counseling/Recommendations

Suicidality/Mental Health
Depression
Anxiety
Suicide ideation
Suicide attempts
History of psychologic counseling
Other mental health diagnosis
Counseling/Recommendations

Confidentiality discussed With teen With parent(s)

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	
DRUG ALLERGIES		CURRENT MEDICATIONS	
WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)

See growth chart.

Name		
ID NUMBER		
TEMPERATURE	BIRTH DATE	AGE

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
--	--	---

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
--	--	---

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

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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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 (if not reviewed in Previsit Questionnaire)

☐ SOCIAL-EMOTIONAL • Tries to do what you do • Helps in the house • Listens to a story	☐ COMMUNICATIVE • Says 2 to 3 words • Brings toys over to show you ☐ COGNITIVE • Scribbles • Follows simple commands	☐ PHYSICAL DEVELOPMENT • Bends down without falling • Walks well • Puts block in a cup • Drinks from a cup with very little spilling
---	--	---

Physical Examination

☒ = NL

Bright Futures Priority

☐ EYES (red reflex, cover/uncover test)

☐ NEUROLOGIC

☐ TEETH (caries, white spots, staining)

Additional Systems

☐ GENERAL APPEARANCE	☐ ABDOMEN
☐ HEAD/FONTANELLE	☐ GENITALIA
☐ EARS/APPEARS TO HEAR	☐ Male/Testes down
☐ NOSE	☐ Female
☐ MOUTH AND THROAT	☐ EXTREMITIES/HIPS
☐ LUNGS	☐ BACK
☐ HEART	☐ SKIN
☐ Femoral pulses	

Abnormal findings and comments

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given	☐ TEMPER TANTRUMS AND DISCIPLINE • Distraction • Praise • Consistency	☐ SAFETY • Car safety seat • Home safety • Poisons • Falls • Burns • Smoke detectors • Carbon monoxide detectors
☐ COMMUNICATION AND SOCIAL DEVELOPMENT • Give limited choices • Stranger anxiety • Read and talk with child	☐ SLEEP ROUTINES AND ISSUES • Consistent routines • Night waking	☐ HEALTHY TEETH • First dentist visit • Healthy oral habits • No bottle

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

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ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE	DATE/TIME	Name	
DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE	AGE M F

Visit with: ☐ Teen alone ☐ Parent(s) alone ☐ Mother ☐ Father ☐ Teen with parents ☐ Other _____

History

☐ Previsit Questionnaire reviewed	☐ Teen has special health care needs
☐ Teen 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)

Menarche: Age _____ Regularity _____

Menstrual problems _____

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Changes since last visit _____

Teen lives with _____

Relationship with parents/siblings _____

Risk Assessment

If not reviewed in Supplemental Questionnaire
(Use other side if risks identified.)

HOME

- Eats meals with family ☐ Yes ☐ No
- Has family member/adult to turn to for help ☐ Yes ☐ No
- Is permitted and is able to make independent decisions ☐ Yes ☐ No

EDUCATION

- Grade _____
- Performance ☐ NL _____
- Behavior/Attention ☐ NL _____
- Homework ☐ NL _____

EATING

- Eats regular meals including adequate fruits and vegetables ☐ Yes ☐ No
- Drinks non-sweetened liquids ☐ Yes ☐ No
- Calcium source ☐ Yes ☐ No
- Has concerns about body or appearance ☐ Yes ☐ No

ACTIVITIES

- Has friends ☐ Yes ☐ No
- At least 1 hour of physical activity/day ☐ Yes ☐ No
- Screen time (except for homework) less than 2 hours/day ☐ Yes ☐ No
- Has interests/participates in community activities/volunteers ☐ Yes ☐ No

DRUGS (Substance use/abuse)

- Uses tobacco/alcohol/drugs ☐ Yes ☐ No

SAFETY

- Home is free of violence ☐ Yes ☐ No
- Uses safety belts/safety equipment ☐ Yes ☐ No
- Impaired/Distracted driving ☐ Yes ☐ No
- Has relationships free of violence ☐ Yes ☐ No

SEX

- Has had oral sex ☐ Yes ☐ No
- Has had sexual intercourse (vaginal, anal) ☐ Yes ☐ No

SUICIDALITY/MENTAL HEALTH

- Has ways to cope with stress ☐ Yes ☐ No
- Displays self-confidence ☐ Yes ☐ No
- Has problems with sleep ☐ Yes ☐ No
- Gets depressed, anxious, or irritable/has mood swings ☐ Yes ☐ No
- Has thought about hurting self or considered suicide ☐ Yes ☐ No

Physical Examination

☒ = NL

Bright Futures Priority

☐ SKIN

☐ BACK/SPINE

☐ BREASTS

☐ GENITALIA

SEXUAL MATURITY RATING _____

Additional Systems

☐ GENERAL APPEARANCE	☐ TEETH
☐ HEAD	☐ LUNGS
☐ EYES	☐ HEART
☐ EARS	☐ GI/ABDOMEN
☐ NOSE	☐ EXTREMITIES
☐ MOUTH AND THROAT	☐ NEUROLOGIC
☐ NECK	☐ MUSCULO-SKELETAL

Abnormal findings and comments _____

Assessment

☐ Well teen

Anticipatory Guidance

☐ Discussed and/or handout given

☐ PHYSICAL GROWTH AND DEVELOPMENT	• Friends/relationships • Family time • Community involvement • Encourage reading/school • Rules/Expectations • Planning for after high school	☐ RISK REDUCTION
• Balanced diet • Physical activity • Limit TV • Protect hearing • Brush/Floss teeth • Regular dentist visits	• Tobacco, alcohol, drugs • Prescription drugs • Sex	☐ VIOLENCE AND INJURY PREVENTION
☐ SOCIAL AND ACADEMIC COMPETENCE	• Decision-making • Mood changes • Sexuality/Puberty	• Seat belts • Guns • Conflict resolution • Driving restriction • Sports/Recreation safety
• Age-appropriate limits	☐ EMOTIONAL WELL-BEING	

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Vision ☐ Cholesterol (18–21 years)

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



Psychosocial Risks
Confidential (To be completed confidentially for teens with identified risk)

Home
Relationship with parents/guardians
Violence in home
Teen's concerns
Autonomy
Counseling/Recommendations

Education
Teen's concerns
Social interactions
Conflicts
Counseling/Recommendations

Eating
Usual diet
Attempts to lose weight by dieting, laxatives, or self-induced vomiting
Regular meals (includes breakfast, limits fast food)
Counseling/Recommendations

Activities
Clubs/Extracurricular
Music/Art
Sports
Religious/Community
TV/Electronics hours/day
Gangs
Counseling/Recommendations

CRAFFT used with permission from Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G.
Validity of the CRAFFT substance abuse screening test among adolescent clinic patients.
Arch Pediatr Adolesc Med. 2002;156:607-614
HEEADSSS used with permission from Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update.
Contemp Pediatr. 2004;21:64-90
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Drugs (Substance Use/Abuse)
Tobacco use
Alcohol
Drugs (street/prescription)
Steroids
CRAFFT (+2 indicates need for follow-up)
C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A - Do you ever use alcohol or drugs while you are by yourself, ALONE?
F - Do you ever FORGET things you did while using alcohol or drugs?
F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T - Have you gotten into TROUBLE while you were using alcohol or drugs?
Counseling/Recommendations

Safety
Impaired/Distracted driving
Sports/recreation safety
Guns
Peer violence
Dating violence
Counseling/Recommendations

Sex
Oral sex
Has had sexual intercourse (vaginal, anal)
Age of onset of sexual activity
Number of partners
Gender of partners
Sexual orientation
Condom use
Contraception
Previous pregnancy
Previous STI
Laboratory/Screening results
Pregnancy test
Pap smear
Chlamydia/Gonorrhea, source
Syphilis
HIV
STI screening laboratory results (specify)
Counseling/Recommendations

Suicidality/Mental Health
Depression
Anxiety
Suicide ideation
Suicide attempts
History of psychologic counseling
Other mental health diagnosis
Counseling/Recommendations

Confidentiality discussed With teen With parent(s)

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
 ☐ COGNITIVE
 • Stacks 2 small blocks

• Laughs in response to others
 • Speaks 6 words
 • Runs

• Knows name of favorite book
 • Points to 1 body part
 • Walks up steps

• 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
 ☐ 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
 ☐ LANGUAGE PROMOTION/HEARING
 ☐ SAFETY

• Family time
 • Time for self and other children
 • Reinforce limits
 • Prepare for new sibling (if necessary)
 • Smoke-free environment
 • Anticipate anxiety
 • Praise
 • Consistent discipline
 • Daily playtime

• Read, talk, and sing
 • Simple words
 • Feelings and emotions
 ☐ TOILET TRAINING READINESS
 • Wait until child is ready
 • Reading books/praise

• 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	



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