Section 7 APPENDIX – I

Preventive Care Forms

Age-Specific Encounter Forms (pp. 2 - 19) ***Updated 2014***

Body Mass Index (BMI) Calculator - Child & Teen (p. 20) ***Updated 2014***

CDC Growth Charts (pp. 21 -29) ***Updated 2014***

Medical and Family History Form - English and Spanish (pp. 30 -31)

Objective Hearing and Vision Form (p. 32) ***Updated 2015***

PEDIATRIC VISIT 3 to 5 DAY

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented ?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**
Maternal Depression? Yes / No
Support?

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

Risk Assessment: TB Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin/Umbilicus
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐
Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐
Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐
Sneezing, hiccoughs, soft spot ☐
Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐
Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120º ☐
Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐
Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐
Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Follow-up newborn hearing screen ☐ _____
3. Next preventive appointment ☐ _____
4. Referrals for identified problems? *(specify)*_____

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_____

Signatures: _____

PEDIATRIC VISIT 0 to 1 MONTH

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**
Maternal Depression? Yes / No
Support?

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

Risk Assessment: TB Circle Positive/Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin/Umbilicus
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐
Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐
Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐
Sneezing, hiccoughs, soft spot ☐
Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐
Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120º ☐
Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐
Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐
Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen ☐ _____
3. Follow-up newborn hearing screen ☐ _____
4. Next preventive appointment ☐ _____
5. Referrals for identified problems? *(specify)*_____

_____
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_____
_____
_____
_____
_____
_____
_____
_____

Signatures: _____

PEDIATRIC VISIT 2 to 3 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**
Maternal Depression? Yes / No

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, Loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No
Risk Assessment: TB Circle: **Positive / Negative (Annual)**

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet _____, dry _____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐
Growth spurts ☐ Avoid solid foods until 4-6 months ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Regards face ☐ Alert ☐ Social smile ☐

Fine Motor: Follows 90 degrees ☐ Grasps ☐

Language: Coos ☐ Laughs ☐

Gross Motor: Head steady when sitting ☐ Hand brought to mouth ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐ Sibling rivalry ☐
Father's involvement ☐

Parenting: Comfort often ☐ Infant developing trust ☐
Holding much of time when awake ☐
Temperaments differ among infants ☐

Play and communication: Infant seat ☐ Mobiles, music, pictures ☐
Talk or sing to baby ☐ Objects to kick or bat at ☐

Health: Fever/taking temp ☐ Rashes ☐ Diarrhea ☐
Second hand smoke ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Poison control # ☐
Hot water set at 120º ☐ Water safety (tub/pool) ☐
Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐
Fall prevention (heights) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen, if not done earlier ☐ _____
3. Follow up newborn hearing screen ☐ _____
4. Next preventive appointment at 4 months ☐
5. Referrals for identified problems? *(specify)*

_____
_____
_____
_____
_____

Signatures: _____

PEDIATRIC VISIT 4 to 5 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No
Risk Assessment: TB Circle: Positive / Negative (Annual)

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Can add cereal; use spoon ☐ Iron in formula ☐
If breast fed, Vitamin D and iron ☐
Introduce single ingredient foods one at a time ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Smiles ☐ Seeks eye contact with parent ☐

Fine Motor: Follows 180 degrees ☐ Grasps rattle ☐
Reaches for toy ☐ Hands together ☐

Language: Vocalizes ☐ Coos ☐ Laughs ☐

Gross Motor: Rolls over belly to back ☐ Lifts chest up ☐
Prone, lifts head 90 degrees ☐ Head steady when sitting ☐
Bears some weight on legs ☐

ANTICIPATORY GUIDANCE:

Social: Schedules/daily routines ☐ Sitter ☐

Parenting: Can't spoil ☐ Different babies have different temperaments ☐

Play and communication: Hanging toys ☐
Respond to baby's "conversation" ☐ Age appropriate toys ☐
Choose toys for shape, size and texture ☐

Health: Teething, drooling, chewing ☐ Clean teeth ☐
Second hand smoke ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Poison control # ☐
Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐
Fall prevention (heights) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations by schedule _____
2. Follow up newborn hearing screen _____
3. Next preventive appointment at 6 months ☐
4. Referrals for identified problems? *(specify)*

_____

_____

_____

_____

_____

_____

Signatures: _____

PEDIATRIC VISIT 6 to 8 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, Loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB (Annual) LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
☐	☐	Skin
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Number of Teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Introduce single ingredient food weekly ☐
Offer cup ☐ Jar/table foods ☐ Avoid small hard foods ☐
Encourage self-feeding ☐ Only water in bedtime bottle ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Shy with strangers ☐ Resists pull toy ☐ Plays peek-a-boo ☐

Fine Motor: Transfers toy hand to hand ☐ Feeds self crackers ☐ Works for toy out of reach ☐

Language: Dada or Mama (non-specific) ☐ Turns to voice ☐
Imitates speech sounds ☐

Gross Motor: Sits alone ☐ Stands holding on ☐
Bears weight on legs ☐ No head lag when pulled to sitting ☐

ANTICIPATORY GUIDANCE:

Social: Fear of strangers ☐ Separation anxiety ☐

Parenting: Emphasize protection over discipline ☐
Temper tantrums: ignore, distract ☐
May need reassurance for separation anxiety ☐

Play and communication: Water and sand play ☐
Toys with moving parts, holes, strings to pull ☐
Beginning speech sounds ☐

Health: Fluoride if well water ☐ Second hand smoke ☐
Clean teeth ☐ Use sunscreen ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Baby proof home ☐
Hot water set at 120º ☐ Poison control # ☐
Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Hot liquids ☐
Water safety (tub/pool) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test, if positive risk assessment ☐ _____
3. Follow up newborn hearing screen ☐ _____
4. Fluoride Varnish Applied? Yes / No
5. Next preventive appointment at 9 months ☐
6. Referrals for identified problems? *(specify)*

_____

_____

Signatures:_____

PEDIATRIC VISIT 9 to 11 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB (Annual) LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dentition (# of teeth)
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____
Bowel/bladder: Number of wet____, dry____ in 24 hours?
Number BM's in 24 hours? _____

Education: Jar/table foods ☐ Offer cup ☐ Avoid small hard foods ☐ Encourage self-feeding/finger foods ☐ Expect messiness/playing with food ☐ Water only bedtime bottle ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)* REQUIRED

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Shy with strangers ☐ Plays patty cake ☐ Looks for fallen object ☐
Fine Motor: Bangs two cubes ☐ Pincer grasp ☐ Reaches, grabs ☐ Feeds self ☐ Drinks from cup ☐
Language: Dada or Mama (specific) ☐ Babbles ☐ Imitates speech sounds ☐
Gross Motor: Gets to sitting ☐ Pulls self to stand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Fear of strangers ☐ Separation anxiety ☐
Parenting: Emphasize protection over discipline ☐ Temper tantrums: ignore, distract ☐ May need reassurance for separation anxiety ☐
Play and communication: Water and sand play ☐ Toys with moving parts, holes, strings to pull ☐ Beginning speech sounds ☐
Health: Fluoride if well water ☐ Second hand smoke ☐ Clean teeth with soft toothbrush or cloth ☐ Use sunscreen ☐
Injury prevention: Rear riding/rear facing infant car seat ☐ Smoke detector/escape plan ☐ Poison control# ☐ Hot liquids ☐ Hot water set at 120° ☐ Water safety (tub, pool) ☐ Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐ Baby proof home ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test referral (if positive risk assessment) ☐_____
3. Fluoride Varnish Applied? Yes / No_____
4. Next preventive appointment at 12 months ☐ _____
5. Referrals for identified problems? *(specify)*_____

_____

_____

Signatures:_____

PEDIATRIC VISIT 12 to 14 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No_____
Evidence of neglect or abuse? Yes / No_____

RISK ASSESSMENT:

	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dental/Number of teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Phase out bottle ☐ Table foods ☐ Vitamins ☐
Decreased appetite ☐ Whole milk until age two ☐
Keep offering new foods ☐ Nutritious snacks ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Fear of strangers ☐ Separation anxiety ☐

Fine Motor: Scribbles ☐ Pincer grasp ☐ Drinks from cup ☐

Language: Dada or Mama (specific) ☐ 1 to 3 words ☐
Indicates wants ☐

Gross Motor: Stands alone ☐ "Cruises" ☐ Walks ☐ Stoops and recovers ☐ Plays ball with examiner ☐

ANTICIPATORY GUIDANCE:

Social: Fear of strangers ☐ Separation anxiety ☐

Parenting: Delay toilet training ☐ Negativism ☐ Autonomy ☐
Discipline means to teach ☐ Avoid spanking/slapping ☐

Play and communication: Varied activities ☐
Singing, naming, reading ☐

Health: Fever ☐ Fluoride if well water ☐ Brush teeth ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Poison control # ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test/HCT required ☐ _____
3. PPD, if positive risk assessment ☐ _____
4. Has parent renewed MA for infant? ☐
5. Dental visit advised ☐_____
6. Fluoride Varnish Applied? Yes / No_____
7. Next preventive appointment at 15 months ☐ _____
8. Referrals for identified problems? *(specify)*_____

_____

_____

_____

_____

Signatures:_____

PEDIATRIC VISIT 15 to 17 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dental/Number of teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Only water in bedtime bottle ☐ Keep offering new foods ☐
Strong dislike for certain foods ☐ Phase out bottle, pacifier ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Imitates affection ☐ Helps with simple tasks ☐
Imitates housework ☐

Fine Motor: Scribbles spontaneously ☐ Uses cup ☐ Feeds self ☐
Tower of 2 cubes ☐

Language: 3 words other than Dada/Mama ☐ Immature babbling ☐
Points to 1-3 named body parts ☐ Understands simple commands ☐

Gross Motor: Crawls up steps ☐ Stoops and recovers ☐
Walks well ☐ Walks backward ☐ Removes garment ☐

ANTICIPATORY GUIDANCE:

Social: Child is egocentric ☐ Loves attention ☐
Seeks to control others ☐

Parenting: Child may bite, hit ☐ Use time out ☐
Temper tantrums: ignore, distract ☐ Avoid spanking/slapping ☐
Discipline is teaching ☐ Dependence verses autonomy needs ☐

Play and communication: Climbing, dancing, riding toys ☐
Likes to push/pull, empty/fill, open/close ☐ Read stories ☐
Enjoys household articles ☐

Health: Regression during illness/stress ☐ Proper shoes ☐
Teeth brushing ☐ Fluoride if well water ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Baby proof home ☐ Hot liquids ☐ Hot water set at 120º ☐
Water safety (tub/pool) ☐ Choking/suffocation ☐ Poison control # ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Review lead and HCT results ☐ _____
3. Refer for lead and HCT testing if not available ☐ _____
4. PPD, if positive risk assessment ☐
5. Dental visit advised ☐ or date of last dental exam_____
6. Fluoride Varnish Applied? Yes / No_____
7. Next preventive appointment at 18 months ☐ _____
8. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 18 to 23 MONTHS

DATE OF SERVICE_____

NAME_____ DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dentition (# of teeth)
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet:

Education: Prolonged mealtime with playing ☐
Likes and dislikes change often ☐ Food jags okay ☐
Allow self-feeding ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)* REQUIRED

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____
MCHAT Required ☐

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Removes clothes ☐ Helps with simple tasks ☐
Imitates housework ☐

Fine Motor: Scribbles ☐ Tower of 3-4 cubes ☐ Turns pages ☐

Language: Combines 2 words ☐ Points to 2-4 named body parts ☐
Follows directions ☐ Names picture (cat, bird, horse, dog, person) ☐
Uses 10-15 words ☐

Gross Motor: Kicks ball ☐ Throws ball ☐ Walks up steps ☐
Walks backward ☐

ANTICIPATORY GUIDANCE:

Social: Needs to be independent ☐ Stubbornness is normal ☐
Does not share well ☐

Parenting: Daily routines meet security needs ☐
Child constantly tests parent, self, siblings, environment ☐
"Time out" for hitting/biting ☐ Avoid spanking, slapping ☐
Forgets rules quickly, needs reminding ☐ Give choices ☐

Play and communication: Uses objects for imaginary play ☐
Manipulative toys (play dough, sand, paint) ☐ Read stories ☐
Thumb sucking and masturbation common ☐
Favorite toy, transitional object ☐

Health: May be toilet ready ☐ Brush teeth ☐ Fluoride if well water ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120° ☐ Water safety (tub, pool) ☐
Poison control no. ☐ Choking/suffocation ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS:

1. Immunizations ordered ☐ _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if risk assessment positive ☐ _____
4. Fluoride Varnish Applied? Yes / No
5. Dental visit advised ☐ or date of last dental visit _____
6. Next preventive appointment at 2 Years ☐_____
7. Referrals for identified problems: (specify)_____

Signatures:_____

PEDIATRIC VISIT 2 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

(Circle)	CHOL	TB	LEAD
	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐
Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____
MCHAT Required ☐

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐
Washes and dries hands ☐ Plays interactive games ☐
Separates from mother ☐

Fine Motor: Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐
Uses spoon well ☐

Language: Combines 2 words ☐ Knows 3-5 named body parts ☐
Follows 2 part directions ☐ Understands cold, tired, hungry ☐
Gives first and last name ☐ Picks longer line ☐
Names 1 picture (cat, bird, horse, dog, person) ☐

Gross Motor: Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐
Balances on 1foot-1 second ☐ Pedals tricycle ☐
Throws ball overhand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Aware of self/different from others ☐ Needs peer contact ☐
Dawdling is normal ☐ Resolving negativism ☐
Power struggles occur ☐

Parenting: Toilet training (relaxed, praise success) ☐ Sexuality ☐
Help teach self-control ☐ Offer choice, give simple tasks ☐
Tantrums (ignore, distract, sympathize) ☐

Play and communication: Small table and chairs ☐
Stories and music ☐ Building materials ☐

Health: Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐
Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐
Physical activity ☐ Second hand smoke ☐ Tick prevention ☐

Injury prevention: Car seat ☐ Rear riding seat ☐ Poison control # ☐
Hot water at 120º ☐ Water safety (tub, pool) ☐ Toddler proof home ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐

PLANS

1. Review immunizations and bring up to date ☐ _____
2. Second Lead/HCT test required ☐ _____
3. Speech referral if delayed ☐ _____
4. PPD, if risk assessment is positive ☐ _____
5. Dental visit advised ☐ Date of Last Dental Exam _____
6. Testing/counseling, if cholesterol risk assessment is positive_____
7. Fluoride Varnish Applied? Yes / No_____
8. Next preventive appointment at 30 Months ☐ _____
9. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 30 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

(Circle)	CHOL	TB	LEAD
	Pos / Neg	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐
Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

REQUIRED if not completed at 24 month visit
ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____
MCHAT Required ☐ if not completed at 24 month visit

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐
Washes and dries hands ☐ Plays interactive games ☐
Separates from mother ☐

Fine Motor: Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐
Uses spoon well ☐

Language: Combines 2 words ☐ Knows 3-5 named body parts ☐
Follows 2 part directions ☐ Understands cold, tired, hungry ☐
Gives first and last name ☐ Picks longer line ☐
Names 1 picture (cat, bird, horse, dog, person) ☐

Gross Motor: Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐
Balances on 1foot-1 second ☐ Pedals tricycle ☐
Throws ball overhand ☐

ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

Social: Aware of self/different from others ☐ Needs peer contact ☐
Dawdling is normal ☐ Resolving negativism ☐
Power struggles occur ☐

Parenting: Toilet training (relaxed, praise success) ☐ Sexuality ☐
Help teach self-control ☐ Offer choice, give simple tasks ☐
Tantrums (ignore, distract, sympathize) ☐

Play and communication: Small table and chairs ☐
Stories and music ☐ Building materials ☐

Health: Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐
Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐
Physical activity ☐ Second hand smoke ☐ Tick prevention ☐

Injury prevention: Car seat ☐ Rear riding seat ☐ Poison control # ☐
Hot water at 120° ☐ Water safety (tub, pool) ☐ Toddler proof home ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐

PLANS

1. Review immunizations and bring up to date ☐ _____
2. Second Lead/HCT test required ☐ if not completed at 24 month visit_____
3. Speech referral if delayed ☐ _____
4. PPD, if risk assessment is positive ☐ _____
5. Dental visit advised ☐ Date of Last Dental Exam _____
6. Testing/counseling, if cholesterol risk assessment is positive_____
7. Fluoride Varnish Applied? Yes / No_____
8. Next preventive appointment at 3 Years ☐ _____
9. Referrals for identified problems? *(specify)* _____

Signatures:_____

PEDIATRIC VISIT 3 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: CHOL TB LEAD

(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No_____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Offer variety of nutritious foods/snacks ☐ May be picky ☐
Eats same foods as family ☐ 5 fruits/vegetables daily ☐
No sweetened beverages ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Dresses self ☐ Separates easily ☐ Plays interactive games ☐
Fine Motor: Copies: O _____ + _____ ☐ _____
Language: Understands 2of 3: cold, tired, hungry ☐
Understands 3 of 4 prepositions (block is on, under, behind in front of table) ☐ Speech clear to examiner ☐ Recognizes 3-4 colors ☐
Uses plurals ☐ Gives first and last name ☐ Knows sex (boy/girl) ☐
Gross Motor: Balances on 1 foot for 1 second ☐ Jumps well ☐
Broad jump ☐ Pedals tricycle ☐

ANTICIPATORY GUIDANCE:

Social: Needs peer contact ☐ Caution with strangers/animals ☐ Sibling rivalry ☐ Develops pride with accomplishments ☐
Caution with strangers/animals ☐

Parenting: Time out for serious misbehavior ☐ Read parenting books ☐
Help child to release energy ☐ Avoid smacking, spanking ☐
Encourage talk about feelings (instead of misbehaving) ☐
Dependency needs alternate with independence ☐
Special times alone with child ☐ Praise child ☐

Play and communication: Excursions, outdoor play, art ☐ Library ☐
Read to child ☐ Make up stories together ☐ Screen TV shows ☐

Health: Dental care ☐ Fears ☐ Physical activity ☐
Begin sex education (boy/girl differences, "private parts", etc) ☐
Masturbation ☐ Fluoride if well water ☐ Tick prevention ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Rear riding car seat ☐ Bicycle helmets ☐ Matches ☐
Riding toys in traffic ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Hot water 120º ☐ Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Water safety (tub, pool) ☐
Toddler proof home ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at 4 Years ☐_____
7. Referrals for identified problems:*(specify)*_____

_____

Signatures:_____

PEDIATRIC VISIT 4 TO 5 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? Yes / No_____
Family health history updated? Yes / No_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB	LEAD
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Choose from food guide pyramid ☐ 2hrs or less TV/day ☐
Child can help prepare food for meals ☐ Mealtime can be fun ☐
5 fruits/vegetables daily ☐ Food jags ☐ 1 or more hrs. physical activity ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: Wnl ☐ **Areas of Concern**:_____
Referred: Yes / No **Where**? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Toilets alone ☐ Dresses self ☐ Plays in group ☐
Separates from parent easily ☐

Fine Motor: Copies: O _____ + _____ ☐ _____
Uses scissors ☐ Draws person, 3 parts ☐

Language: Knows: What is:- spoon ☐; shoe ☐; door ☐;-made of?
Fluent sentences ☐ Recognizes 3-4 colors ☐ Defines 6-9 words: Ball ☐
Lake ☐ Desk ☐ House ☐ Banana ☐ Curtain ☐ Ceiling ☐ Fence ☐
Knows 2-3 opposites: fire is hot, ice is __ ☐; mom is woman, dad is __ ☐;
horse is big, mouse is ___ ☐

Gross Motor: Balances on 1 foot for 10 seconds (2-3 times) ☐
Hops ☐ Heel-toe walk ☐ Catches bounced ball ☐

ANTICIPATORY GUIDANCE:

Social: School readiness ☐ Enrolled in Pre-K/K ☐ School avoidance ☐
Management of aggression ☐ Promote self-help skills ☐
Caution with strangers/animals ☐

Parenting: Allow separation ☐ Promote initiative, creativity ☐
Awareness of ADHD and learning disabilities ☐

Play and communication: Monitor TV use ☐ Small chores ☐
Creative, active and group play ☐

Health: Dental care ☐ Fluoride if well water ☐ Bedwetting ☐ Fears ☐
Nightmares ☐ Leg aches ☐ Normal sexual curiosity; simple answers ☐
Masturbation ☐ Oedipal complex ☐ Use sunscreen ☐
Tick prevention ☐ Second hand smoke ☐

Injury prevention: Booster seat (up to 4'9") ☐ Ride in back seat ☐
Riding toys in traffic environment ☐ Bicycle helmets ☐ Matches ☐
Choking/suffocation ☐ Hot water 120° ☐ Water safety (tub, pool) ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Fall prevention (playground) ☐ Smoke detector/escape plan ☐
Firearms (look alike toys, owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐ _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*

_____

Signatures:_____

PEDIATRIC VISIT 6 to 11 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Child care:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:

	CHOL	TB
(Circle)	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose/Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner stage
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose foods from food guide pyramid ☐ Sociable at table ☐
Lowfat food choices, including milk ☐ Choose healthy foods at school ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐ 2hrs or less TV ☐

DEVELOPMENTAL SURVEILLANCE:

School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Responsibility for self ☐, for school ☐ Competitiveness ☐
Family vs. peer activities ☐ Caution with strangers/animals ☐
Teach address and phone number ☐

Parenting: Increased autonomy in decisions ☐ Communicate ☐
Praise and encourage ☐ Give allowance ☐
Assist in handling money ☐ Establish fair rules ☐

Play and communication: Organized sports ☐ Hobbies ☐
Monitor TV use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐
Physical activity ☐ Smoking ☐ Second hand smoke ☐
Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Early sex education ☐
Masturbation ☐ Modesty ☐

Injury prevention: Seat belt ☐ Rear seat until age 12 years ☐
Riding toys in traffic environment ☐ Bicycle helmets ☐ Water safety ☐
Hot water 120° ☐ Fall prevention (playground) ☐ Matches ☐
Protective devices in sports ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, products) ☐ Poison control # ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Objective Hearing and Vision Tests (recommended)_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*_____

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Signatures:_____

PEDIATRIC VISIT 12 TO 13 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/____% HEIGHT_____/____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

RISK ASSESSMENT: CHOL TB STI/HIV

(Circle) Pos / Neg Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:
Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods ☐ Sociable at table ☐
Avoid fad diets/eating disorders ☐ Select healthy snacks ☐
5 fruits/vegetables daily ☐ 2 hrs or less of TV/computer games ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:
Peer Relations:
Family Relations:
Extracurricular activities:
Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Family and peer activities ☐ Ownership and competition ☐
Responsibility for self and family ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Money, allowance ☐
Promote mutual & self-respect ☐ Respect privacy ☐ Allow decisions ☐
Spend time with child talking, projects ☐

Play and communication: Organized sports ☐
Monitor TV and internet use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Masturbation ☐
Modesty ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmet ☐ Riding in traffic ☐
Smoke detector/escape plan ☐ Poison control # ☐ Water safety ☐
Protective devices in sports ☐ Alcohol/drug use ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Recommend objective Hearing and Vision Tests ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Testing for sickle cell trait if original metabolic results not available ☐
7. Dental visit advised ☐ or date of last visit_____
8. Next preventive appointment at _____
9. Referrals for identified problems: Yes / No *(specify)*_____

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_____

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Signatures:_____

PEDIATRIC VISIT 12 TO 13 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

RISK ASSESSMENT: CHOL TB STI/HIV

(Circle) Pos / Neg Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:
Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods ☐ Sociable at table ☐
Avoid fad diets/eating disorders ☐ Select healthy snacks ☐
5 fruits/vegetables daily ☐ 2 hrs or less of TV/computer games ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:
Peer Relations:
Family Relations:
Extracurricular activities:
Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Family and peer activities ☐ Ownership and competition ☐
Responsibility for self and family ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Money, allowance ☐
Promote mutual & self-respect ☐ Respect privacy ☐ Allow decisions ☐
Spend time with child talking, projects ☐

Play and communication: Organized sports ☐
Monitor TV and internet use ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Masturbation ☐
Modesty ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmet ☐ Riding in traffic ☐
Smoke detector/escape plan ☐ Poison control # ☐ Water safety ☐
Protective devices in sports ☐ Alcohol/drug use ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. Recommend objective Hearing and Vision Tests ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Testing for sickle cell trait if original metabolic results not available ☐
7. Dental visit advised ☐ or date of last visit_____
8. Next preventive appointment at _____
9. Referrals for identified problems: Yes / No *(specify)*_____

_____

_____

_____

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Signatures:_____

PEDIATRIC VISIT 14 TO 16 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? Yes / No_____
Family health history updated? Yes / No_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

RISK ASSESSMENT:

	CHOL	TB	STI/HIV
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth (symptoms of eating disorders?) _____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition _____
☐	☐	Neck/Nodes
☐	☐	Lungs _____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts _____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes _____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

Nutritional Assessment:

Typical diet *(specify foods)*:

Symptoms of eating disorder? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Food sources of iron, calcium, folic acid ☐
Select healthy foods ☐ Prevent obesity ☐ Eat breakfast ☐
Avoid eating disorders/fad diets ☐ 2 hrs or less of TV/computer games ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Confidentiality ☐ Peer group pressures ☐ Mood swings ☐
Dependence vs. independence ☐ Establishing own values ☐
Social misconduct due to family dysfunctions ☐ Future plans ☐
Stay in school ☐ Love life ☐ ETOH use ☐ Drug Abuse ☐

Parenting: Establish fair, negotiable rules ☐ Allow decisions ☐
Provide support, encouragement ☐ Money, allowance ☐
Promote mutual respect ☐ Respect privacy ☐

Health: Dental care ☐ Personal hygiene ☐ Fluoride ☐ Menstruation ☐
Breast/testicular self-exam ☐ Smoking ☐ Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Prepare for physical changes ☐ Birth control ☐ STDs ☐
Sexual Responsibility ☐

Injury prevention: Seat belt ☐ Alcohol/drug use ☐ Bicycle helmets ☐
Protective devices in sports ☐ Water safety ☐
Smoke detector/escape plan ☐ Firearms (owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. PPD, if positive risk assessment ☐_____
3. Recommend Objective Hearing and Vision Tests ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Dental visit advised ☐ or date of last visit_____
7. Next preventive appointment at _____
8. Referrals for identified problems: Yes / No *(specify)*

_____
_____
_____
_____

Signatures:_____

PEDIATRIC VISIT 17 TO 20 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

RISK ASSESSMENT: CHOL TB STI/HIV

(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? No / Yes Counseling provided? No / Yes
Referral? No / Yes To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:
Symptoms of eating disorder? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Select healthy foods ☐ Use skim milk/and lowfat foods ☐
Avoid fad diets ☐ 2 hrs or less of TV/computer games ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐
Vitamin/mineral supplements, folic acid for females ☐ Eat breakfast ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School:
Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Love life ☐ Peer groups pressures ☐ Mood swings ☐
Social misconduct resulting from family dysfunctions ☐
Establishing own values ☐ Future plans ☐ Stay in school ☐

Parenting: Support ☐ Prepare for independence ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Menstruation ☐ Breast/testicular self-exam ☐
Physical activity ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Birth control ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmets ☐
Protective devices in sports ☐ Smoke detector/escape plan ☐
Firearms (owner risk/safe storage) ☐ Alcohol/drug use ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐ _____
2. PPD if positive risk assessment ☐ _____
3. Testing/counseling if positive cholesterol risk assessment ☐_____
4. Testing if positive STD/HIV risk assessment ☐ _____
5. Dental visit advised ☐ or date of last visit ☐ _____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*

_____
_____
_____
_____
_____
_____

Signatures:_____

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

BMI Percentile Calculator for Child and Teen
English Version

This calculator provides BMI and the corresponding BMI-for-age percentile on a CDC BMI-for-age growth chart. Use this calculator for children and teens, aged 2 through 19 years old. For adults, 20 years old and older, use the Adult BMI Calculator (http://www.cdc.gov/healthyweight/assessing/bmi/adult_BMI/english_bmi_calculator/bmi_calculator.html).

Measuring Height and Weight Accurately At Home (http://www.cdc.gov/healthyweight/assessing/bmi/childrens_BMI/measuring_children.html)

BMI Calculator for Child and Teen

(English | Metric (Calculator.aspx?CalculatorType=Metric))

1. **Birth Date:**

   Month ▾ Day ▾ Year ▾

2. **Date of Measurement:**

   Month ▾ Day ▾ Year ▾

3. **Sex:**

   ○ Boy ○ Girl

4. **Height, to nearest 1/8 inch:**

   Feet Inches Fractions of an inch

   0 ▾ 0 ▾ 0 ▾

   (12 inches = 1 foot; Example: 4 feet, 5 1/2 inches)

5. **Weight, to nearest 1/4 (.25) pound:**

   Weight (pounds): Fractions of a pound:

   0 0 ▾

(8 ounces = 1/2 pounds; Example: 75 3/4 pounds)

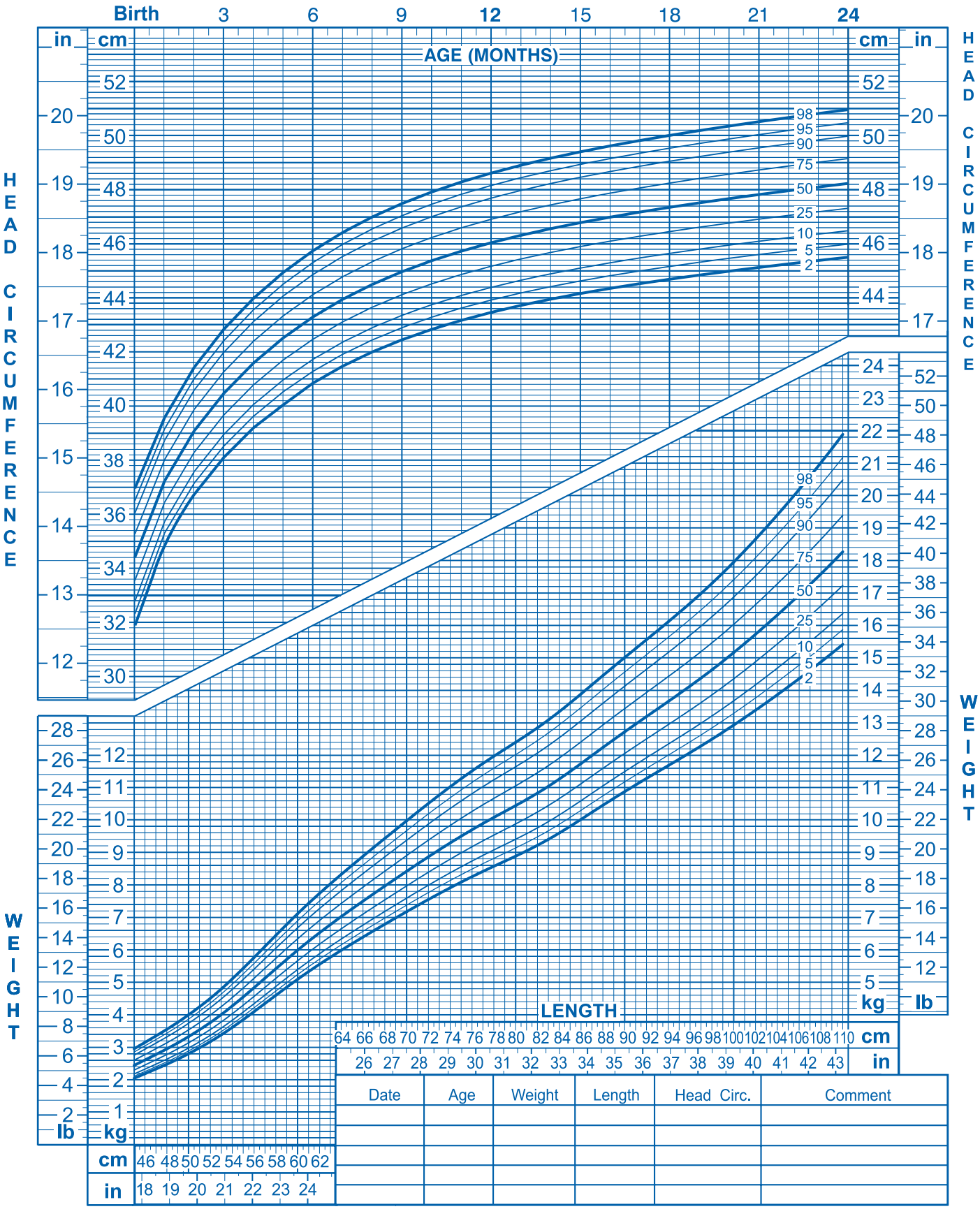
Calculate

Note: Please keep in mind that this BMI calculator is not meant to serve as a source of clinical guidance and is not intended to be a substitute for professional medical advice. Because BMI is based on weight and height, it is only an indicator of body fatness. Individuals with the same BMI may have different amounts of body fat. Persons may consider seeking advice from their health-care providers on healthy weight status and to consider individual circumstances.

Birth to 24 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



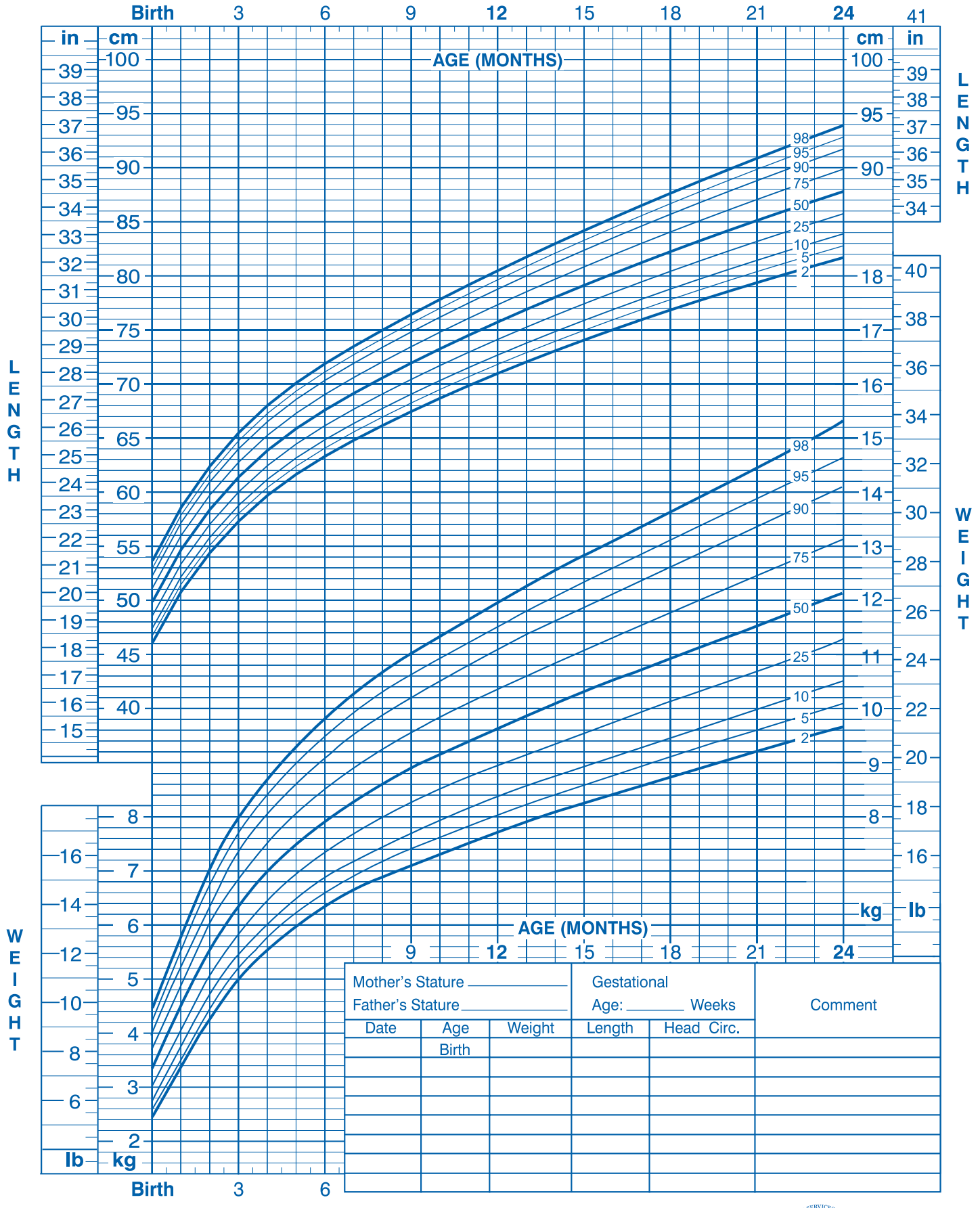
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____

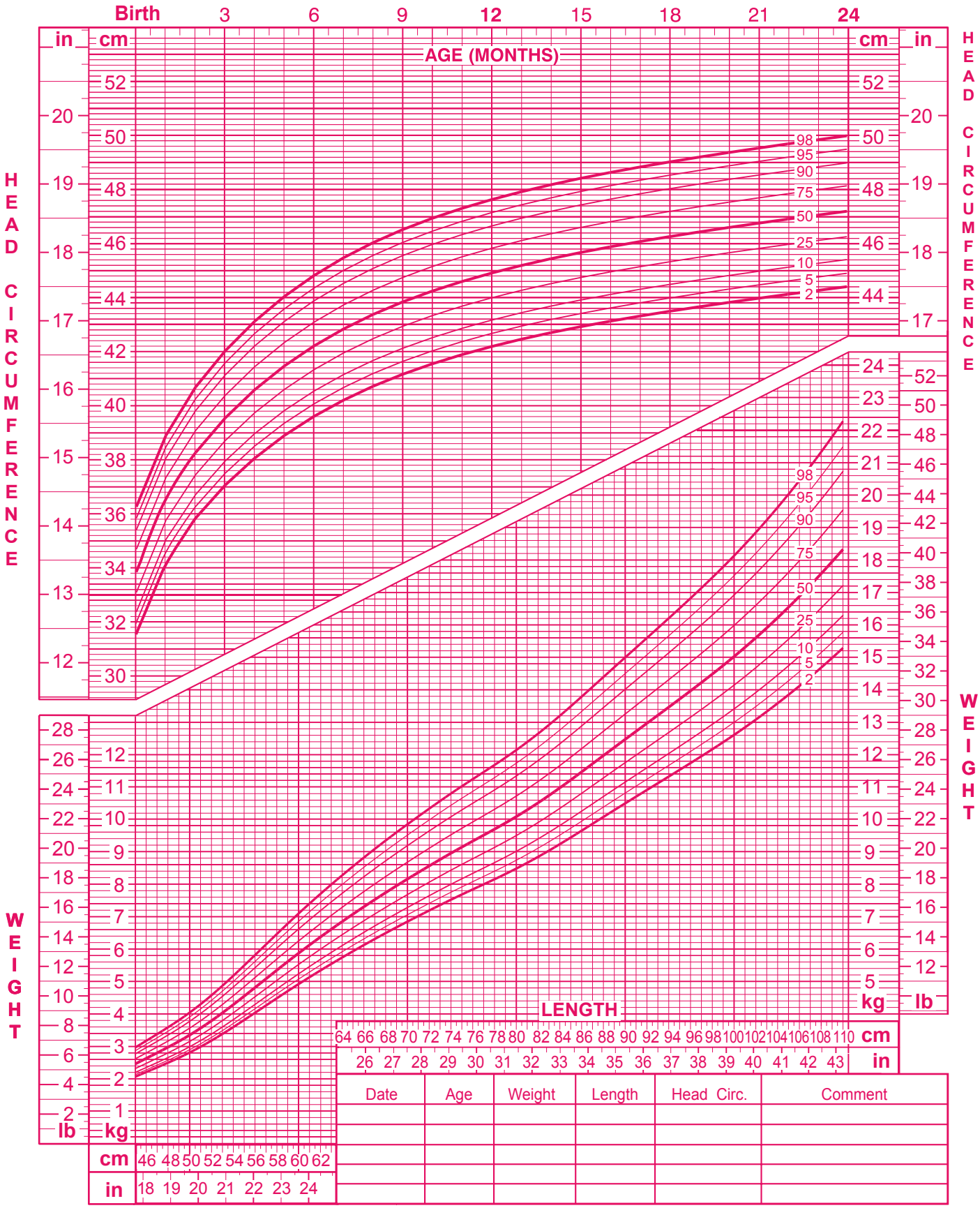


Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



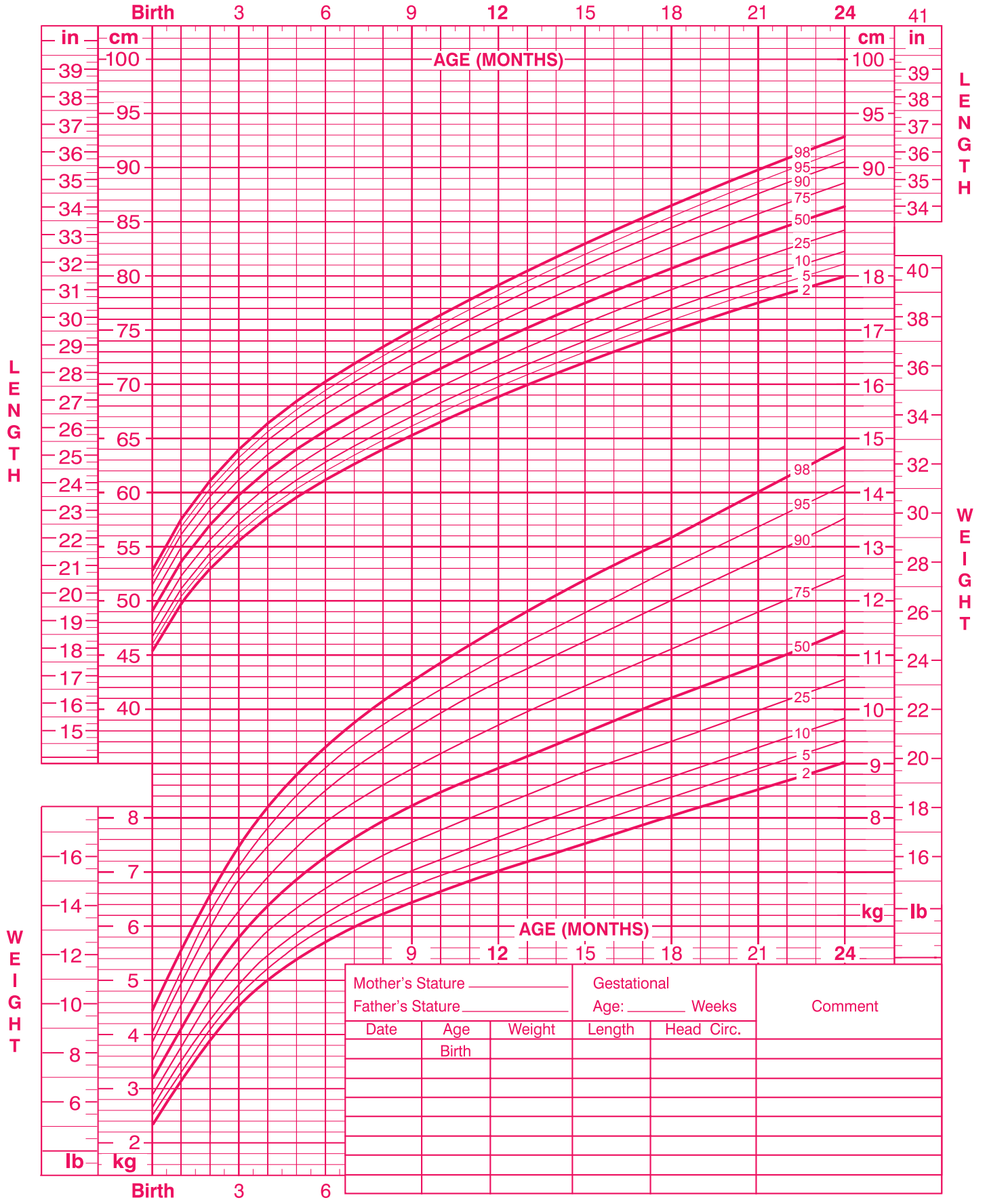
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

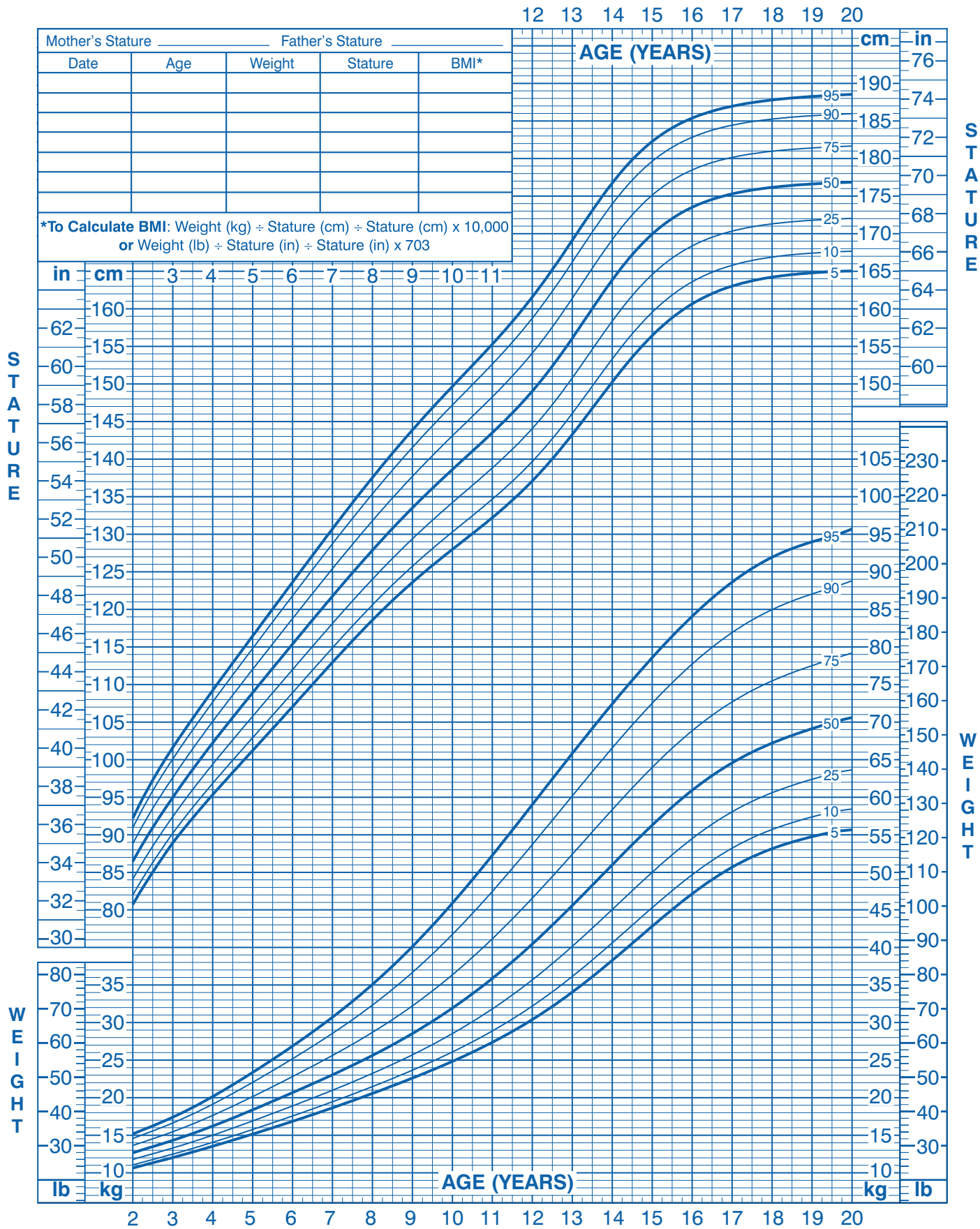
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER • HEALTHIER • PEOPLE™

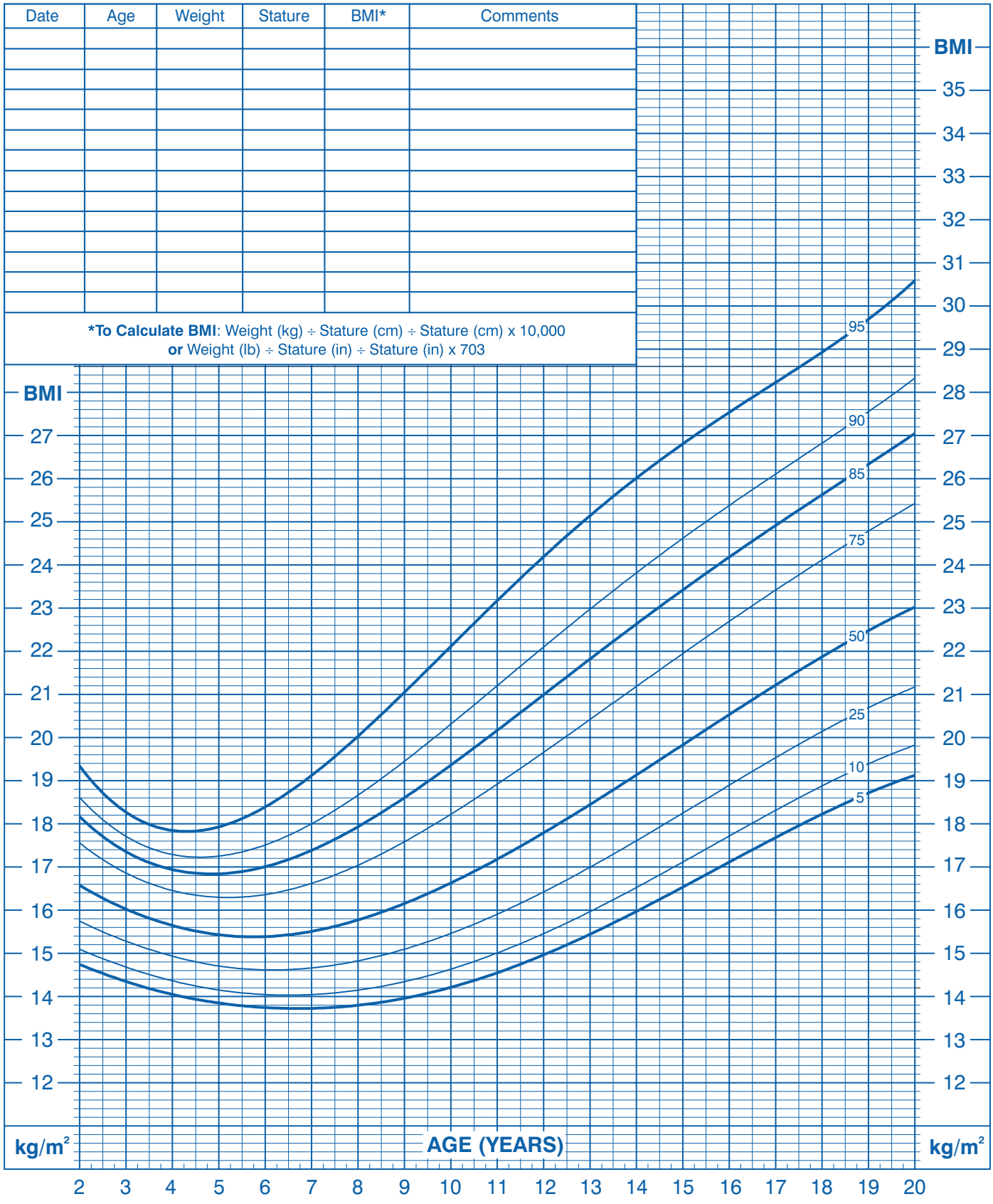
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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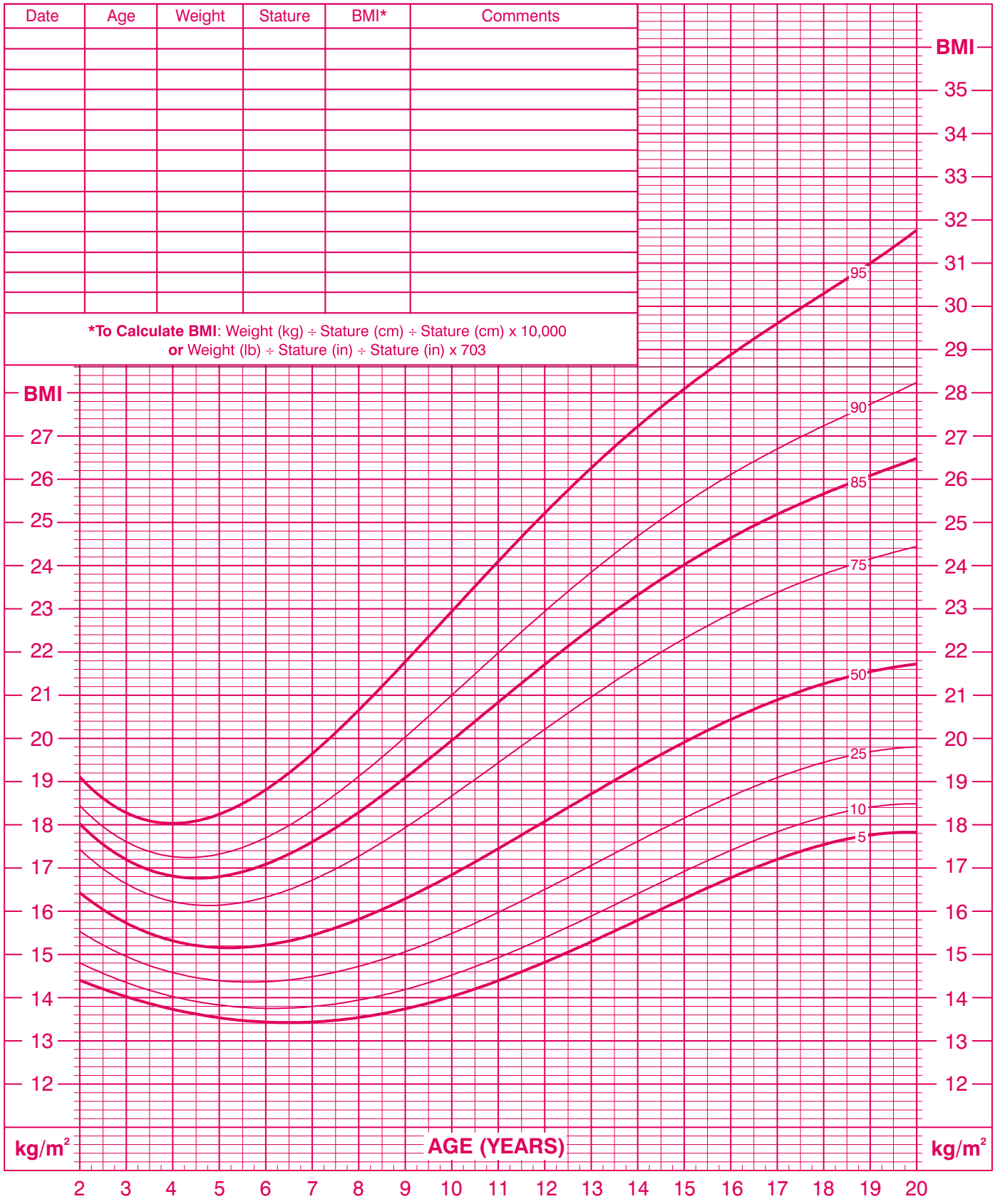
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER • HEALTHIER • PEOPLE™

2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703

Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

Maryland Healthy Kids Program

Cuestionario de Historial Médico Familiar

Nombre del Paciente:	Fecha de Nacimiento:	Sexo: M F (circule)
Persona que llenó el Formulario:	Fecha de Hoy:	Relación con el Paciente::

HISTORIAL DURANTE EMBARAZO Y AL NACER

Nombre del Hospital: _____
Enfermedades durante el embarazo No ☐ Si☐
Medicamentos durante embarazo No ☐ Si☐
Abuso de Alcohol o drogas No ☐ Si☐
Problemas al Nacer No ☐ Si☐
Describa: _____
Tipo de Parto ☐ Vaginal ☐ Cesárea
Peso al Nacer_____Peso al darle de alta_____
El bebé recibió vacuna para Hepatitis B No☐ Si ☐
Fecha de la vacuna de Hepatitis B:_____
Examen Auditivo para recien nacidos No ☐ Si ☐

HISTORIAL PSICOSOCIAL

¿Quién vive en el hogar?_____
_____
¿Cuántas personas viven en el hogar?_____
☐ Alquilan ☐ casa propia ☐ refugio
¿Quién cuida el niño/a?_____
Fecha de Nacimiento Madre_____
Padre_____
Trabajan los Padres Madre No ☐ Si ☐
Padre No ☐ Si ☐
Hogar Sustituto _____Fecha:_____
¿Qué otro idiomas se hablan en la casa?_____
_____

HISTORIAL FAMILIAR

Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:

Alergias (a qué) _____	No ☐	Si ☐	¿Quién?
Asma	No ☐	Si ☐	
TB/Enfermedad del Pulmón	No ☐	Si ☐	
VIH/SIDA	No ☐	Si ☐	
Intentos Suicidas/Problemas Mentales	No ☐	Si ☐	
Enfermedad del Corazón	No ☐	Si ☐	
Presión alta/Derrame	No ☐	Si ☐	
Colesterol Alto	No ☐	Si ☐	
Desórdenes de la Sangre/"Sickle Cell"	No ☐	Si ☐	
Diabetes	No ☐	Si ☐	
Convulsiones	No ☐	Si ☐	
Alergias/Asma	No ☐	Si ☐	
Desórdenes Mentales	No ☐	Si ☐	
Cáncer	No ☐	SI ☐	
Defectos de Nacimiento	No ☐	Si ☐	
Pérdida de Audición	No ☐	Si ☐	
Problemas de habla	No ☐	Si ☐	
Enfermedades Renales	No ☐	Si ☐	
Abuso de Alcohol/ Droga	No ☐	Si ☐	
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐	
Enfermedad de la Tiroide	No ☐	Si ☐	
Problemas de Aprendizaje/ Deficit de Atención ("ADD")	No ☐	Si ☐	
Violencia Doméstica			
Otras:_____			

HISTORIAL DE SALUD

Alguna vez su niño/a ha tenido:

Alergias (a qué)_____			
Asma	No ☐	Si ☐	
Varicela (año) _____	No ☐	Si ☐	
Infecciones frecuentes de oído	No ☐	Si ☐	
Problemas de Audición/Infecciones de la Vista	No ☐	Si ☐	
Problemas de la Piel/Eczema	No ☐	Si ☐	
Asma/Alergias	No ☐	Si ☐	
TB/Enfermedad del Pulmón	No ☐	Si ☐	
Convulsiones/Epilepsia	No ☐	Si ☐	
Hipertensión/Presión Alta	No ☐	Si ☐	
Enfermedad del Corazón/Defectos	No ☐	Si ☐	
Hepatitis/Enfermedad del Hígado	No ☐	Si ☐	
Diabetes	No ☐	Si ☐	
Enfermedades del Riñón/Vejiga	No ☐	Si ☐	
Problemas Físicos o de Aprendizaje	No ☐	Si ☐	
Desórdenes de la Sangre/Hemofilia	No ☐	Si ☐	
Enfermedades Transmitidas Sexualmente	No ☐	Si ☐	
Problemas Emocionales o de Comportamiento	No ☐	Si ☐	
Depresión/Pensamientos Suicidas	No ☐	Si ☐	
Hospitalizaciones/Cirugías	No ☐	Si ☐	
Abuso /Físico/Emocional/ o Sexual	No ☐	Si ☐	
Problemas en las Coyunturas/Huesos	No ☐	Si ☐	
Obesidad/Trastornos Alimenticios	No ☐	Si ☐	

Otras: _____
Lista de Medicamento/s que toma:_____

Revisado por:	Fecha que fue Revisado:

OBJECTIVE HEARING AND VISION TESTING
MARYLAND HEALTHY KIDS PROGRAM

Child's Name:_____ Date of Birth_____

Objective Vision Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

Ages 3 – 6

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Vision Fusion:
Pass _____ Fail _____

Color Screens (optional):
Pass _____ Fail _____

Comments: _____

_____

Date of Service: _____

Screened by: _____

Ages 8 – 20

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Hyperopia:
Pass _____ Fail _____

Pass _____ Fail _____

Comments: _____

_____

.....

Objective Hearing Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____