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 a dental home
☐ 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 (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™

This American Academy of Pediatrics Visit Documentation Form is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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