

Name _____		BIRTH DATE _____	AGE _____	ACCOMPANIED BY/INFORMANT _____	PREFERRED LANGUAGE _____
		<input type="checkbox"/> M <input type="checkbox"/> F			
ID NUMBER _____	CURRENT MEDICATIONS _____ See other side for current medication list		DRUG ALLERGIES _____		
WEIGHT (%) _____	LENGTH (%) _____	WEIGHT FOR LENGTH (%) _____	HEAD CIRC (%) _____	TEMPERATURE _____	DATE/TIME _____

See growth chart.

**BF** = Bright Futures Priority Item

**History**

**BF**  Previsit Questionnaire reviewed

**BF**  Child has special health care needs

**BF** Concerns/questions raised by \_\_\_\_\_  
 None    Addressed (see other side)

**BF** Follow-up on previous concerns  None    Addressed (see other side)

**BF**  Medication Record reviewed and updated

Newborn Screening  NL

Hearing Screening  NL

**Physical Examination**

= Reviewed w/Findings   **OR**    NL = Reviewed/Normal

**BF**  GENERAL APPEARANCE \_\_\_\_\_  NL

**BF**  SKIN (rashes, bruising) \_\_\_\_\_  NL

**BF**  HEAD / FONTANELLE (positional skull deformities) \_\_\_\_\_  NL

**BF**  EYES (red reflex/strabismus/appears to see) \_\_\_\_\_  NL

EARS/APPEARS TO HEAR \_\_\_\_\_  NL

NOSE \_\_\_\_\_  NL

MOUTH AND THROAT \_\_\_\_\_  NL

NECK \_\_\_\_\_  NL

LUNGS \_\_\_\_\_  NL

**BF**  HEART \_\_\_\_\_  NL

**BF**  FEMORAL PULSES \_\_\_\_\_  NL

ABDOMEN \_\_\_\_\_  NL

HERNIA \_\_\_\_\_  NL

GENITALIA \_\_\_\_\_  NL

Male/Testes down \_\_\_\_\_  NL

Female \_\_\_\_\_  NL

**BF**  NEUROLOGIC / GAIT (tone, strength, symmetry) \_\_\_\_\_  NL

EXTREMITIES \_\_\_\_\_  NL

**BF**  MUSCULOSKELETAL (torticollis) \_\_\_\_\_  NL

**BF**  HIPS \_\_\_\_\_  NL

NO DYSMORPHISMS \_\_\_\_\_  NL

HYGIENE \_\_\_\_\_  NL

BACK \_\_\_\_\_  NL

**Social/Family History**

**BF** Family situation  Single Parent

**BF** Parent adjustment to child \_\_\_\_\_

**BF** Maternal Depression  Yes  No

PHQ 9  Pass    Refer

PHQ 2  Pass    Refer

Edinburgh  Pass    Refer

**BF** Parents working outside home:  Mother    Father

**BF** Child care:  Yes    No   Type \_\_\_\_\_

**BF** Changes since last visit \_\_\_\_\_

Heat source \_\_\_\_\_

**BF**  Tobacco Exposure

**BF** Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Review of Systems**

= NL

Date of last visit \_\_\_\_\_

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

**Assessment**

**BF**  Well Child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Anticipatory Guidance**

= Discussed and/or handout given

Identified at least one child and parent strength

Raising Reader book given

Describe immunization side effects & when to call

<p><b>BRIGHT FUTURES</b></p> <p><input type="checkbox"/> PARENTAL (MATERNAL) WELL-BEING</p> <p><input type="checkbox"/> INFANT-FAMILY SYNCHRONY</p> <p><input type="checkbox"/> NUTRITIONAL ADEQUACY</p> <ul style="list-style-type: none"> <li>Breastfeeding (400 IU vitamin D supplement)</li> <li>Iron-fortified formula</li> <li>Solid foods (wait until 4-6 months)</li> <li>Elimination</li> <li>No bottle in bed</li> </ul>	<p><input type="checkbox"/> INFANT BEHAVIOR</p> <ul style="list-style-type: none"> <li>Calming skills</li> <li>Physical                             <ul style="list-style-type: none"> <li>Tummy time</li> <li>Daily routines</li> </ul> </li> <li>Sleep                             <ul style="list-style-type: none"> <li>Back to sleep</li> </ul> </li> </ul>	<p><input type="checkbox"/> SAFETY</p> <ul style="list-style-type: none"> <li>Car safety seat (infant rear facing)</li> <li>Falls</li> <li>Burns                             <ul style="list-style-type: none"> <li>Hot liquids</li> <li>Water heater</li> </ul> </li> <li>Smoke-free environment</li> <li>Drowning</li> <li>Choking</li> <li>Small objects</li> <li>Plastic bags</li> <li>Sun Safety</li> </ul>
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**Development** (if not reviewed in Previsit Questionnaire)

<p><input type="checkbox"/> PHYSICAL DEVELOPMENT</p> <ul style="list-style-type: none"> <li>*Lifts head and begins to push up when prone</li> <li>*Holds head erect for short periods (when held upright)</li> <li>*Diminished newborn reflexes</li> <li>*Symmetrical movement</li> </ul>	<p><input type="checkbox"/> COMMUNICATIVE</p> <ul style="list-style-type: none"> <li>*Coos</li> <li>*Different cries for different needs</li> </ul> <p><input type="checkbox"/> COGNITIVE</p> <ul style="list-style-type: none"> <li>*Indicates boredom when no activity change</li> </ul> <p><input type="checkbox"/> SOCIAL-EMOTIONAL</p> <ul style="list-style-type: none"> <li>*Smiles</li> <li>*Looks at parent</li> <li>*Self-comfort</li> </ul>
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(see other side for plan, immunizations and follow-up)

