

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 (%)	HEIGHT (%)	BMI (%)	BMI RANGE: <input type="checkbox"/> <5% (under) <input type="checkbox"/> 5-84% (healthy) <input type="checkbox"/> 85-94% (over) <input type="checkbox"/> 95-98% (obese) <input type="checkbox"/> ≥99% (obese)	HEAD CIRC (%)	TEMPERATURE
					DATE/TIME

See growth chart.

BF = Bright Futures Priority Item

History

BF Previsit Questionnaire reviewed

BF Child has a dental home 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

Social/Family History

BF Family situation Single Parent

BF Parents working outside home: Mother Father

BF Child care: Yes No Type _____

BF Changes since last visit _____

BF Tobacco Exposure

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 _____
 Formula Ounces per feeding _____
 Milk (24oz/day) _____ Ounces per day _____
 Wean to a cup
 Meals times/day _____
 Nutrition, balanced, eats with family
Source of water _____ Vitamins/Fluoride _____

Elimination: NL _____

Sleep: NL _____

Behavior: NL _____

Activity (playtime, no TV): NL _____

Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> PHYSICAL DEVELOPMENT *Bangs toys together *Pulls to stand *Stands alone *Drinks from a cup	<input type="checkbox"/> COMMUNICATIVE *Speaks 1-2 words *Babbles *Tries to make the same sounds you do *Looks at things you are looking at
<input type="checkbox"/> SOCIAL-EMOTIONAL *Waves bye-bye *Tries to do what you do *Cries when you leave *Plays peekaboo *Hands you a book to read	<input type="checkbox"/> COGNITIVE *Follows simple directions

(see other side for plan, immunizations and follow-up)

Physical Examination

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

GENERAL APPEARANCE _____ NL

SKIN _____ NL

HEAD / FONTANELLE _____ NL

BF EYES (red reflex, cover/uncover test) _____ NL

EARS/APPEARS TO HEAR _____ NL

NOSE _____ NL

MOUTH AND THROAT _____ NL

BF TEETH (caries, white spots, staining) _____ NL

NECK _____ NL

LUNGS _____ NL

HEART _____ NL

FEMORAL PULSES _____ NL

ABDOMEN _____ NL

HERNIA _____ NL

BF GENITALIA _____ NL

BF Male/Testes down _____ NL

BF Female _____ NL

BF NEUROLOGIC / GAIT (tone, strength, gait) _____ NL

EXTREMITIES _____ NL

MUSCULOSKELETAL (torticollis) _____ NL

HIPS _____ NL

HYGIENE _____ NL

BACK _____ NL

BF Comments _____

Assessment

BF Well Child

Anticipatory Guidance

= Discussed and/or handout given

Identified at least one child and parent strength

Raising Readers book given

BF <input type="checkbox"/> FAMILY SUPPORT • Time for self/partner • Community activities • Age-appropriate discipline	<input type="checkbox"/> FEEDING AND APPETITE CHANGES • Self-feeding • Consistent meals/snacks • Variety of nutritious foods • Iron-fortified formula	<input type="checkbox"/> SAFETY • Car safety seat (infant rear facing) • Poisons • Water • No supervision by young children • Sharp objects • Guns • Home safety • Falls • Sun safety
BF <input type="checkbox"/> ESTABLISHING ROUTINES • Family traditions • Nap and bedtime	<input type="checkbox"/> ESTABLISHING A DENTAL HOME • First dentist visit • Brush teeth twice a day • Limit bottle use (water only) • No bottle in bed	

BRIGHT FUTURES

BRIGHT FUTURES

