

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
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WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	DATE/TIME
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See growth chart.

BF = Bright Futures Priority Item

History

BF Previsit Questionnaire reviewed 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 _____
 Solid foods / finger foods _____ 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 *Sits well *Crawls *Pulls to feet with support	<input type="checkbox"/> COMMUNICATIVE *Imitates sounds *Points out objects
<input type="checkbox"/> SOCIAL-EMOTIONAL *Stranger anxiety *Seeks parent for comfort	<input type="checkbox"/> COGNITIVE *Peekaboo *Object permanence *Looks at books

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

Physical Examination

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

GENERAL APPEARANCE _____ NL
 SKIN _____ NL

BF HEAD / FONTANELLE (positional skull deformities) _____ NL
BF EYES (ocular mobility, eye alignment, red reflex) _____ NL

EARS/APPEARS TO HEAR _____ NL
 NOSE _____ NL
 MOUTH AND THROAT _____ NL
 TEETH _____ 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 of movements, parachute reflex) _____ NL
 EXTREMITIES _____ NL

BF MUSCULOSKELETAL (torticollis) _____ NL
BF 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

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

BRIGHT FUTURES

BRIGHT FUTURES

