

Name _____		BIRTH DATE _____	AGE _____	ACCOMPANIED BY/INFORMANT _____	PREFERRED LANGUAGE _____
		<input type="checkbox"/> M <input type="checkbox"/> F			
ID NUMBER _____	CURRENT MEDICATIONS _____ <small>See other side for current medication list</small>		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 _____
<small>See growth chart.</small>					

**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     Bottle     Cup  
 Milk (24oz/day) \_\_\_\_\_ Ounces per day \_\_\_\_\_  
 Solid Foods     Juice     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)

**Structured developmental screen**  NL

**Developmental Screening Tool**

ASQ score \_\_\_\_\_  pass     refer

PEDS score \_\_\_\_\_  pass     refer

**Autism-specific screen**  NL

MCHAT Part I score \_\_\_\_\_  pass     refer

MCHAT Part II (only if part I fails) score \_\_\_\_\_  pass     refer

**PHYSICAL DEVELOPMENT**     **COMMUNICATIVE**  
 \*Stacks 2 small blocks                      \*Speaks 6 words  
 \*Runs    \*Brings toys over to show you  
 \*Walks up steps  
 \*Uses spoon and cup without spilling most of the time

**COGNITIVE**  
 \*Knows name of favorite book  
 \*Points to 1 body part

**SOCIAL-EMOTIONAL**  
 \*Helps in the house  
 \*Laughs in response to others

## Physical Examination

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

GENERAL APPEARANCE \_\_\_\_\_  NL

**BF**  **SKIN (nevi, café au lait, bruising)** \_\_\_\_\_  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

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

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

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

**BF**  **NEUROLOGIC (gait, coordination)** \_\_\_\_\_  NL

EXTREMITIES/HIPS \_\_\_\_\_  NL

MUSCULOSKELETAL \_\_\_\_\_  NL

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

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

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

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

## Assessment

**BF**  Well Child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Anticipatory Guidance

= Discussed and/or handout given

Identified at least one child and parent strength

Raising Readers book given

Keep home/car smoke free

<p><input type="checkbox"/> <b>FAMILY SUPPORT</b></p> <ul style="list-style-type: none"> <li>• Family time</li> <li>• Time for self and other children</li> <li>• Reinforce limits</li> <li>• Prepare for new sibling (if necessary)</li> </ul> <p><input type="checkbox"/> <b>TOILET TRAINING READINESS</b></p> <ul style="list-style-type: none"> <li>• Wait until child is ready</li> <li>• Reading books/praise</li> </ul>	<p><input type="checkbox"/> <b>CHILD DEVELOPMENT AND BEHAVIOR</b></p> <ul style="list-style-type: none"> <li>• Anticipate anxiety</li> <li>• Praise</li> <li>• Consistent discipline</li> <li>• Daily playtime</li> <li>• Your child's behavior</li> </ul> <p><input type="checkbox"/> <b>LANGUAGE PROMOTION / HEARING</b></p> <ul style="list-style-type: none"> <li>• Read, talk and sing</li> <li>• Simple words</li> <li>• Feelings and emotions</li> </ul>	<p><input type="checkbox"/> <b>SAFETY</b></p> <ul style="list-style-type: none"> <li>• Car safety seat (infant rear facing)</li> <li>• Poisons</li> <li>• Burns</li> <li>• Smoke detectors</li> <li>• Guns</li> <li>• Falls</li> </ul>
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BRIGHT FUTURES

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