

NAME:
DOB:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y N
Findings:

TB questionnaire*, risk identified: Y N
*Tuberculin Skin Test if indicated TST
(See back for form)

- DEVELOPMENTAL SURVEILLANCE:**
- Communication skills/language development
 - Self-help/care skills
 - Social, emotional development
 - Cognitive development
 - Mental health

NUTRITION*:
Problems: Y N
Assessment:

*See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

Up-to-date
 Deferred - Reason:

Given today: DTaP Hep A Hep B Hib IPV
 Meningococcal* MMR Pneumococcal*
 Varicella MMRV DTaP-IPV
 DTaP-IPV-Hep B Influenza

*Special populations: See ACIP

LABORATORY

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _____ (_____ %) Height: _____ (_____ %)
BMI: _____ (_____ %) Heart Rate: _____
Blood Pressure: _____ / _____ Respiratory Rate: _____
Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Head | <input type="checkbox"/> Mouth/throat | <input type="checkbox"/> GI/abdomen |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Teeth | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal |
| | | <input type="checkbox"/> Neurological |

Abnormal findings:

Audiometric Screening:
R 1000Hz _____ 2000HZ _____ 4000HZ _____
L 1000Hz _____ 2000HZ _____ 4000HZ _____

Visual Acuity Screening:
OD ____ / ____ OS ____ / ____ OU ____ / ____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE (See back for useful topics)

- Selected health topics addressed in any of the following areas*:
- School Activities
 - Nutrition
 - Development
 - Safety
 - Physical Activities

*See Bright Futures for assistance

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y
Other Referral(s)

Return to office: _____

Signature/title

Signature/title

