

Newborn Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +
B/P if indicated /

Nutrition

Breast _____ min. q. _____ hrs.

Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

Wet diapers per day _____

Strong stream (if male)? Yes No

Stools per day _____

WIC yes no

Problems

Constipation Yes No

Sleep Yes No

Spitting up Yes No

Excessive crying Yes No

Physical Exam undressed: yes no √ = nl X = abnl

General

Head

Fontanel

Neck

Eyes

Red reflex

Ears

Nose

Throat/Mouth

Lungs

Heart

Abdomen

Femoral Pulses

Umbilical Cord

Genitalia

Female

Male

Testes

Circ.

Spine

Extremities

Hips

Skin

Neuro

Safety

Car seat, facing backwards

Smoke free environment

Smoke detectors in home

Hot water < 120 degrees

No bottle propping

Sleep on back

Firm, well fitting crib mattress

Never shake the baby

Health

↑ feedings to 26 – 32 oz per day

Sponge bathe

Cord, circumcision care

Bowel movements

Fever > 100.4

Social/Behavioral

Who makes up family

Support for mother

Baby's temperament

Cuddle, talk, rock

Sleep

Impression

Well Newborn

Premature Infant

Jaundice

Plan/Referrals

Immunizations current? Yes No

Hepatitis B #1 (if indicated)

V.I.S./Counseling

RTC 1 month _____

_____ M.D. / P.N.P.

PROV# _____

See back for additional documentation

Hearing Risk Assessment

Responds to sounds yes no

Newborn hearing screen:

Passed Repeat scheduled _____

Vision Risk Assessment

Looks at parent's face yes no

Newborn Metabolic/Hemoglobinopathy

Screening Normal Repeat Pending

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

One Month Visit

Tennessee Chapter of the

American Academy of Pediatrics

Tennessee Pediatric Society



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated /

Nutrition

Breast _____ min. q. _____ hrs.

Formula _____ oz. q. _____ hrs.

Brand _____

With iron? Yes No

Water: city well spring bottled

WIC: yes no

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

- | | | |
|--------------|-----|----|
| Spitting up | yes | no |
| Constipation | yes | no |
| Colic | yes | no |
| Stuffy nose | yes | no |
| Sleep | yes | no |

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

Hearing Risk Assessment

Responds to sounds yes no

Newborn hearing screen:

Passed Repeat scheduled _____

Vision Risk Assessment

Looks at parent's face yes no

Follows with eyes yes no

TB Risk Assessment* — +

Newborn Metabolic/Hemoglobinopathy Screening normal repeat pending

Physical Exam undressed : yes no √= nl X = abnl

- General
- Head
- Fontanel
- Neck
- Eyes
- Red Reflex
- Ears
- Nose
- Throat/Mouth
- Lungs
- Heart
- Abdomen
- Femoral Pulses
- Umbilical Cord
- Genitalia
 - Female
 - Male
 - Testes
 - Circ.
- Spine
- Extremities
- Hips
- Skin
- Neuro

Safety

- Car seat, facing backwards
- Smoke free environment
- Smoke detectors in home
- Hot water < 120 degrees
- No bottle propping
- Sleep on back
- Crib Safety
- Never shake the baby

Health/Nutrition

- If bottle fed, 26-32 oz/day
- If breast fed, nurses 8-10 times/day
- Delay solids
- Bowel movements
- Strong urinary stream, if male
- Fever

Social/Behavioral

- Temperament
- Sleep
- Talk to baby
- Support for mother
- Day care plans yes no

Impression

- Well Baby
- Normal Growth
- Normal Development
- _____
- _____

Plan/Referrals

- Immunizations current? yes no
- Hepatitis B vaccine
- V.I.S./Counseling
- Vitamin D if breast fed
- One month Handout sheet
- RTC at 2 months _____
- _____
- _____
- _____

_____. M.D. / P.N.P.

PROV# _____

See back for additional documentation

Revised 06/09

*see separate form

Two Month Visit

Tennessee Chapter of the
American Academy of Pediatrics

Tennessee Pediatric Society

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated _____ / _____

Nutrition

o Breast _____ times per day

o Formula _____ oz. per day

Brand _____

With iron? Yes No

Cereal yes no

Water: city well spring bottled

WIC: yes no

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Spitting up yes no

Constipation yes no

Colic yes no

Stuffy nose yes no

Sleep yes no

Diaper rash yes no

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

Hearing Risk Assessment

Responds to sounds yes no

Smiles and laughs yes no

Newborn hearing screen:

Pass Repeat Not done

Vision Risk Assessment

Looks at parent's face yes no

Follows with eyes yes no

Newborn Metabolic/Hemoglobinopathy

Screening normal repeat pending

*see separate form

Physical Exam

undressed : yes no √ = nl X = abnl

General

Head

Fontanel

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Spine

Extremities

Hips

Skin

Neuro

Safety

Car seat, facing backwards

Smoke free environment

Smoke detectors in home

Hot water < 120 degrees

No bottle propping

Sleep on back

Crib Safety

Rolling over, prevent falls

Health/Nutrition

If bottle fed, 26-32 oz/day

If breast fed, nurses 8-10 times/day

Delay solids

Bowel movements

Strong urinary stream, if male

Fever

Social/Behavioral

Temperament

Sleep

Talk to baby

Support for mother

Day care plans yes no

Impression

Well Baby

Normal Growth

Normal Development

Plan/Referrals

Immunizations current? Yes No

DTaP, IPV, Hib, Hep B, PCV-7, Rota

V.I.S./Counseling

Acetaminophen _____ mg. q. 4 hrs.

Vitamin D, if breast fed

Two month Handout sheet

RTC at 4 months _____

M.D. / P.N.P.

PROV# _____

See back for additional documentation

Revised 06/09

Four Month Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated /

Nutrition

Breast _____ times per day

Formula _____ oz. per day

Brand _____

With iron? yes no

Cereal /baby food yes no

Water: city well spring bottled

WIC: yes no

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Spitting up yes no

Constipation yes no

Sleep yes no

Diaper rash yes no

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

Speech/Hearing Risk Assessment

Responds to sounds yes no

Babbles and coos yes no

Vision Risk Assessment

Looks at parent's face yes no

Follows with eyes yes no

Anemia Risk Assessment — +

Physical Exam

undressed : yes no √= nl X = abnl

General

Head

Fontanel

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Extremities

Spine

Hips

Skin

Neuro

Safety

Car seat, facing backwards

Smoke free environment

Smoke detectors in home

Hot water < 120 degrees

No bottle propping

Fall prevention

Bath Safety

No baby walkers

Child proof home

Health/Nutrition

If bottle fed, 26-32 oz/day

If breast fed, nurses 8-10 times/day

Introduce solids

Avoid honey

Teething

Social/Behavioral

Temperament

Sleep, bedtime routine

Talk, read to baby

Family support

Day care yes no

Impression

Well Baby

Normal Growth

Normal Development

Plan/Referrals

Immunizations current? Yes No

DTaP, IPV, Hib, Hep B, PCV-7, Rota

V.I.S./Counseling

Acetaminophen _____ mg. q. 4 hrs.

Vitamin D and iron supplement, if breast fed

Four month Handout sheet

RTC at 6 months _____

_____ M.D. / P.N.P.

PROV# _____

See back for additional documentation

* see separate form

Six Month Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +
B/P if indicated /

Nutrition

Breast _____ times per day

Formula _____ oz. per day

Brand _____

With iron? Yes No

Water: city well spring bottled
fluoridated

Cereal/Baby food yes no

Servings per day _____

WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Constipation yes no
Sleep yes no
Diaper rash yes no

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

Speech/Hearing Risk Assessment

Responds to sounds yes no
Jabbers and laughs yes no

Vision Risk Assessment

Looks at parent's face yes no
Follows with eyes yes no

TB Risk Assessment* — +

Lead Risk Assessment* — +

* see separate form

Physical Exam

undressed : yes no √= nl X = abnl

General	<input type="checkbox"/>
Head	<input type="checkbox"/>
Fontanel	<input type="checkbox"/>
Neck	<input type="checkbox"/>
Eyes	<input type="checkbox"/>
Red Reflex	<input type="checkbox"/>
Alignment	<input type="checkbox"/>
Ears	<input type="checkbox"/>
Nose	<input type="checkbox"/>
Throat/Mouth/Teeth	<input type="checkbox"/>
Lungs	<input type="checkbox"/>
Heart	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>
Femoral Pulses	<input type="checkbox"/>
Genitalia	
Female	<input type="checkbox"/>
Male	<input type="checkbox"/>
Testes	<input type="checkbox"/>
Extremities	<input type="checkbox"/>
Hips	<input type="checkbox"/>
Spine	<input type="checkbox"/>
Skin	<input type="checkbox"/>
Neuro	<input type="checkbox"/>

Safety

- Car seat, facing backwards
- Smoke detectors in home
- Hot water < 120 degrees
- Always supervise bath
- Rolling over, prevent falls
- No baby walkers
- Child proof home
- Sun exposure

Health/Nutrition

- Continue formula or breast milk
- Introduce meats, finger food
- Introduce cup, juice
- Avoid honey
- Teething/clean teeth
- No bottle in bed or bottle propping

Social/Behavioral

- Temperament
- Sleep, bedtime routine
- Talk, read to baby
- Family support
- Day care yes no

Impression

- Well Baby
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current? Yes No
- DTaP, IPV, Hib, Hep B, PCV-7, Rota
- Influenza vaccine
- V.I.S./Counseling
- Acetaminophen _____ mg. q. 4 hrs.
- Fluoride gts. 0.25 mg. daily
- Vitamin D and iron, if breast fed
- Dental Referral (if at risk)
- Six month Handout sheet
- RTC at 9 months _____
- _____
- _____

M.D. / P.N.P.

PROV# _____

- See back for additional documentation
- Revised 06/09

Nine Month Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +
 B/P if indicated /

Nutrition

- Breast _____ times per day
- Formula _____ oz. per day

Brand _____
 With iron? Yes No
 Water: city well spring bottled
 fluoridated
 Baby food _____ servings/day
 Table food Yes No
 WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development learning or behavior?

No Yes _____

Developmental/Behavioral Screening*

Normal Abnormal

Speech/Hearing Risk Assessment

Responds to sounds yes no
 Imitates speech yes no

Vision Risk Assessment

Notices small objects yes no

Lead Risk Assessment* — +

Physical Exam	undressed : yes	no	√ = nl	X = abnl
General	<input type="checkbox"/>			
Head	<input type="checkbox"/>			
Fontanel	<input type="checkbox"/>			
Neck	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>			
Red Reflex	<input type="checkbox"/>			
Alignment	<input type="checkbox"/>			
Ears	<input type="checkbox"/>			
Nose	<input type="checkbox"/>			
Throat/Mouth/Teeth	<input type="checkbox"/>			
Lungs	<input type="checkbox"/>			
Heart	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>			
Femoral Pulses	<input type="checkbox"/>			
Genitalia				
Female	<input type="checkbox"/>			
Male	<input type="checkbox"/>			
Testes	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>			
Hips	<input type="checkbox"/>			
Spine	<input type="checkbox"/>			
Skin	<input type="checkbox"/>			
Neuro	<input type="checkbox"/>			

Safety

- Car seat, facing backwards
- Smoke detectors in home
- Smoke free environment
- Hot water < 120 degrees
- Always supervise bath
- Fall prevention, gates
- Child proof home
- Poison Control Number
- Sun exposure

Health/Nutrition

- Continue formula or breast milk
- Introduce table, finger foods
- Choking prevention
- Avoid honey
- Introduce cup, weaning
- Teething/clean teeth
- No bottle in bed or bottle propping

Social/Behavioral

- Exploring, set consistent limits
- Sleep, bedtime routine
- Talk, read to baby
- Family
- Day care yes no

Impression

- Well Baby
- Normal growth
- Normal development
- _____
- _____

Plan/Referrals

- Immunizations current yes no
- Hep B
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Acetaminophen _____ mg. q. 4. hrs.
- Vitamin D and iron, if breastfed
- Fluoride gtt. 0.25 mg. daily
- Dental referral (if at risk)
- Nine month handout sheet
- RTC at 12 months _____
- _____
- _____
- _____

 M.D. / P.N.P.

PROV# _____

- See back for additional documentation
- Revised 06/09

* see separate form

12 Month Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated /

Nutrition

Whole milk yes no

Weaned from bottle? yes no

Appetite: good variable picky

fruits _____

vegetables _____

meats _____

Water: city well spring bottled

fluoridated

WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development or behavior?

No Yes _____

Developmental/Behavioral Screening*

(if clinically indicated)

Normal Abnormal

Speech/Hearing Risk Assessment

Hears well yes no

Says 2-4 words yes no

Vision Risk Assessment

Notices small objects yes no

Lead Risk Assessment* — +

TB Risk Assessment* — +

IPPD result (if at risk) _____

Lab Tests

Hgb _____

Lead level _____

(recommended by TennCare)

* see separate form

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Fontanel

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth/Teeth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Extremities

Hips/Gait

Spine

Skin

Neuro

Impression

Well Child

Normal growth

Normal development

Plan/Referrals

Immunizations current? Yes No

Varicella, PCV-7, Hib, Hep B, Hep A, IPV, MMR

Catch-up/at risk imm. _____

Influenza vaccine

V.I.S./Counseling

Acetaminophen _____ mg. q. 4 hrs.

Vitamin drops with Iron

Fluoride gtt. 0.25 mg. daily

Dental Referral

12 month handout sheet

RTC at 15 months _____

PROV# _____ M.D. / P.N.P.

See back for additional documentation

Revised 06/09

15 Month Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated /

Nutrition

Whole milk yes no

Weaned from bottle? yes no

Appetite: good variable picky

fruits _____

vegetables _____

meats _____

Water: city well spring bottled

Fluoridated

WIC: Yes No

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development learning or behavior?

No Yes _____

Developmental/Behavioral Screening *

(If clinically indicated)

Normal Abnormal

Speech/Hearing Risk Assessment

Hears well yes no

Says 3-6 words yes no

Vision Risk Assessment

Notices small objects yes no

Lead Risk Assessment* — +

Lab Tests

Hgb _____

(if not done 12 months)

Lead level _____

(if TennCare and not done at 12 months)

*See separate form

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Fontanel

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth/Teeth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Extremities

Hips/Gait

Spine

Skin

Neuro

Safety

Car seat, facing forward if > 20#

Smoke detectors in home

No smoking in home

Hot water < 120 degrees

Water safety, supervise bath

Child proof home

Close supervision

Poison Control Number

Sun exposure

Health/Nutrition

Weaned from bottle

Whole milk until age two

Limit juice, milk intake

Picky appetites, self feeding

Offer variety of foods

Choking prevention

Brushing teeth

Social/Behavioral

Set consistent limits, discipline

Praise good behavior

Discourage hitting, biting and other aggressive behavior

Sleep, bedtime routine

Talk, read to child

Family

Impression

Well Child

Normal growth

Normal development

Plan/Referrals

Immunizations current? Yes No

MMR, Hib, Varicella, PCV-7, Hep B, Hep A, DTaP

Catch-up/at risk imm. _____

Influenza vaccine

V.I.S./Counseling

Acetaminophen _____ mg. q. 4 hrs.

Vitamin drops with iron

Fluoride gtt. 0.25 mg. daily

15 month handout sheet

RTC at 18 months _____

PROV# _____ M.D. / P.N.P.

See back for additional documentation

Revised 06/09

18 Month Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. W/L _____ %tile Head circ. _____ cm Temp. _____ T R

Blood Pressure Risk Assessment — +
 B/P if indicated /

Nutrition
 Whole milk yes no
 Weaned from bottle? yes no
 Appetite: good variable picky
 fruits _____
 vegetables _____
 meats _____

Water: city well spring bottled
 WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?
 No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development learning or behavior?

No Yes _____

Developmental/Behavioral Screening*
 Normal Abnormal

Autism Screening*
 Normal Abnormal

Speech/Hearing Risk Assessment

Hears well yes no
 Says 15-20 words yes no

Vision Risk Assessment
 Notices small objects yes no

Anemia Risk Assessment — +

Lead Risk Assessment* — +

TB Risk Assessment* — +

Physical Exam	undressed	yes	no	√ = nl	X = abnl
General		<input type="checkbox"/>			
Head		<input type="checkbox"/>			
Fontanel		<input type="checkbox"/>			
Neck		<input type="checkbox"/>			
Eyes		<input type="checkbox"/>			
Red Reflex		<input type="checkbox"/>			
Alignment		<input type="checkbox"/>			
Ears		<input type="checkbox"/>			
Nose		<input type="checkbox"/>			
Throat/Mouth/Teeth		<input type="checkbox"/>			
Lungs		<input type="checkbox"/>			
Heart		<input type="checkbox"/>			
Abdomen		<input type="checkbox"/>			
Femoral Pulses		<input type="checkbox"/>			
Genitalia					
Female	<input type="checkbox"/>				
Male	<input type="checkbox"/>				
Testes	<input type="checkbox"/>				
Extremities		<input type="checkbox"/>			
Hips/Gait		<input type="checkbox"/>			
Spine		<input type="checkbox"/>			
Skin		<input type="checkbox"/>			
Neuro		<input type="checkbox"/>			

Safety

- Car seat in back seat
- Smoke detectors
- No smoking in home
- Hot water < 120 degrees
- Water safety, supervise bath
- Child proof home
- Close supervision
- Poison Control Number
- Sun exposure

Health/Nutrition

- Weaned from bottle
- Whole milk until age two
- Limit juice, milk intake
- Picky appetites, self feeding
- Offer variety of foods
- Choking prevention
- Brushing teeth

Social/Behavioral

- Set consistent limits, discipline
- Praise good behavior
- Time out, tantrums
- Toilet training
- Talk, read to child
- Family
- Day care, pre-school yes no

Impression

- Well Child
- Normal growth
- Normal development
- _____
- _____

Plan/Referrals

- Immunizations current? Yes No
- DTaP, MMR, Hep B, Hep A
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Acetaminophen _____ mg. q. 4 hrs.
- Vitamin drops with iron
- Fluoride gtt. 0.25 mg. daily
- Dental referral
- 18 month handout sheet
- RTC at 2 years _____
- _____
- _____

PROV# _____ M.D. / P.N.P.
 See back for additional documentation
 Revised 06/09

* see separate form

24 Month Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Height _____ in. Head circ. _____ cm BMI _____ %tile Temp. _____ T R

Blood Pressure Risk Assessment — +

B/P if indicated _____ / _____

Nutrition

Weaned from bottle? yes no

Appetite: good variable picky

fruits _____

vegetables _____

meats _____

bread _____

Water: city well spring bottled

WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?

No Yes _____

Dyslipidemia Risk Assessment

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development learning or behavior?

No Yes _____

Developmental/Behavioral Screening* (if clinically indicated)

Normal Abnormal

Autism Screening*

Normal Abnormal

Speech/Hearing Risk Assessment

Hears well yes no

2-3 word sentences yes no

Vision Risk Assessment

Sees distant objects well? yes no

Anemia Risk Assessment — +

Lead Risk Assessment* — +

TB Risk Assessment* — +

Lab Tests

Lead level _____

(Required by TennCare at 12 and 24 months)

Cholesterol (if at risk) _____

*See separate form

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth/Teeth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Extremities

Gait

Spine

Skin

Neuro

Safety

- Car seat in back seat of car
- Use bike helmet
- Smoke detectors
- No smoking in home
- Hot water < 120 degrees
- Water safety, supervise bath
- Child proof home, supervision
- Poison Control Number
- Firearm safety
- Sunburn prevention

Health/Nutrition

- Low fat milk from cup
- Limit juice, milk intake
- Picky appetites, self feeding
- Choking prevention
- Brushing teeth
- Encourage active play

Social/Behavioral

- Set limits, time out
- Praise good behavior
- TV limits
- Read to child
- Toilet training
- Sleep, bedtime routine
- Family
- Day care, pre-school yes no

Impression

- Well Child
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- Hep A
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Fluoride gts. 0.25 mg. Daily
- Dental Referral
- Vitamin drops with Iron
- 2 year handout sheet
- RTC at 2 1/2 years

M.D./ P.N.P.

PROV# _____

See back for additional documentation

Revised 06/09

30 Month Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Height _____ in. W/L _____ %tile Temp. _____ T R

Blood Pressure Risk Assessment — +
 B/P if indicated /

Nutrition
 Weaned from bottle? yes no
 Appetite: good variable picky
 fruits _____
 vegetables _____
 meats _____
 bread _____

Water: city well spring bottled
 WIC: Yes No

Dental Risk Assessment — +

Interval History/New Problems

Changes in the family history*?

No Yes _____

Are there any new problems or illnesses since the last visit?

No Yes _____

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development learning or behavior?

No Yes _____

Developmental/Behavioral Screening*

Normal Abnormal

Speech/Hearing Risk Assessment

Hears well yes no
 2-3 word sentences yes no

Vision Risk Assessment

Sees distant objects well? yes no

Lead Risk Assessment* — +

Anemia Risk Assessment — +

Physical Exam	undressed : yes	no	√ = nl	X = abnl
General	<input type="checkbox"/>			
Head	<input type="checkbox"/>			
Neck	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>			
Red Reflex	<input type="checkbox"/>			
Alignment	<input type="checkbox"/>			
Ears	<input type="checkbox"/>			
Nose	<input type="checkbox"/>			
Throat/Mouth/Teeth	<input type="checkbox"/>			
Lungs	<input type="checkbox"/>			
Heart	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>			
Femoral Pulses	<input type="checkbox"/>			
Genitalia				
Female	<input type="checkbox"/>			
Male	<input type="checkbox"/>			
Testes	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>			
Gait	<input type="checkbox"/>			
Spine	<input type="checkbox"/>			
Skin	<input type="checkbox"/>			
Neuro	<input type="checkbox"/>			

Impression

- Well Child
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Fluoride gtt. 0.25 mg. Daily
- Dental Referral
- Vitamin drops with Iron
- 2 1/2 year handout sheet
- RTC at 3 years

 M.D./ P.N.P.

PROV# _____

- See back for additional documentation

Revised 06/09

*See separate form

3 Year Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Height _____ in. BMI _____ %tile B/P _____ Temp. _____ T R O

Nutrition

Low fat milk, cup only yes no
 Appetite: good variable picky
 fruits _____
 vegetables _____
 meats _____
 bread _____

Water: city well spring bottled
 fluoridated

WIC: Yes No

Interval History/New Problems

Changes in the family history*?

No Yes _____

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Are there any new problems or illnesses
 since the last visit?

No Yes _____

Physical Exam

	undressed : yes	no	√ = nl	X = abnl
General	<input type="checkbox"/>			
Head	<input type="checkbox"/>			
Neck	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>			
Red Reflex	<input type="checkbox"/>			
Alignment	<input type="checkbox"/>			
Ears	<input type="checkbox"/>			
Nose	<input type="checkbox"/>			
Throat/Mouth/Teeth	<input type="checkbox"/>			
Lungs	<input type="checkbox"/>			
Heart	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>			
Femoral Pulses	<input type="checkbox"/>			
Genitalia				
Female	<input type="checkbox"/>			
Male	<input type="checkbox"/>			
Testes	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>			
Gait	<input type="checkbox"/>			
Spine	<input type="checkbox"/>			
Skin	<input type="checkbox"/>			
Neuro	<input type="checkbox"/>			

Developmental/Behavioral Surveillance

Do you have any concerns about your
 child's development, learning or
 behavior ?

No Yes _____

Developmental/Behavioral Screening*

(if clinically indicated)

Normal Abnormal

Speech/Hearing Risk Assessment

Hears well ? yes no

Talks well ? yes no

Easy to understand? yes no

Vision (if uncooperative retest in 6mos)

L _____ R _____

Sees distant objects well? yes no

Lead Risk Assessment* — +

TB Risk Assessment* — +

Anemia Risk Assessment — +

Safety

- Car safety seat, back seat safest
- Bike helmet
- Smoke detectors
- No smoking in home
- Water safety, supervise bath
- Outdoor safety, supervision
- Poison Control #
- Firearm safety
- Sunburn prevention

Health/Nutrition

- Low fat milk from cup
- Limit juice, milk intake
- Picky appetites, self feeding
- Low fat foods, healthy snacks
- Brush teeth, see dentist
- Encourage active play

Social/Behavioral

- Discipline, time out
- Praise good behavior
- TV limits, read to child
- Toilet training
- Self help skills
- Family
- Friends and playmates
- Curiosity about sex
- Day care, pre-school yes no

Impression

- Well Child
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Chewable vitamins with iron
- Fluoride gtts. 0.5 mg. Daily
- Dental referral
- 3 year handout sheet
- RTC at 4 years

PROV # _____ M.D./ P.N.P.

See back for additional documentation
 Revised 06/09

* see separate form

4 Year Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Height _____ in. BMI _____ %tile BP _____ Temp. _____ T R O

Interval History/New Problems

Changes in the family history*?

No Yes _____

Dyslipidemia Risk Assessment

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Are there any new problems or illnesses since the last visit?

No Yes _____

Nutrition

Appetite: good variable picky

Water: city well spring bottled

WIC: Yes No

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development, learning or behavior?

No Yes _____

Developmental / Behavioral Screening* (if clinically indicated)

Hearing/Speech

Hears well? yes no

Talks well? yes no

Easy to understand? yes no

Hearing screening test
referred not referred unable to test

Vision:

Notices small objects yes no

Vision screening test:

L _____ R _____

Lead Risk Assessment* — +

TB Risk Assessment* — +

Anemia Risk Assessment — +

Lab Tests

Cholesterol (if at risk) _____

* see separate form

Physical Exam undressed: yes no √= nl X = abnl

General

Head

Neck

Eyes

Red Reflex

Alignment

Ears

Nose

Throat/Mouth/Teeth

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia

Female

Male

Testes

Extremities

Gait

Spine

Skin

Neuro

Safety

Car seat or booster seat if > 40 #

Back seat is safest

Never put child in front seat if you have air bags

Bike helmet

Smoke detectors

No smoking in home

Firearm safety

Water safety, swimming lessons

Outdoor safety, supervision

Sunburn prevention

Health/Nutrition

Low fat milk

Encourage fruits and vegetables

Brush teeth, see dentist

Encourage active play

Social/Behavioral

Discipline, time out

Praise good behavior

TV limits, read to child

Dresses self, helps at home

Family

Friends and playmates

Curiosity about sex

Day care, pre-school yes no

Impression

Well Child

Normal growth

Normal development

Plan/Referrals

Immunizations current yes no

DTaP

Catch-up/at risk imm. _____

Influenza vaccine

V.I.S./Counseling

Chewable vitamins with iron

Fluoride gts. 0.5 mg. Daily

Dental referral

4 year handout sheet

RTC at 5 years

PROV # _____ M.D./ P.N.P.

See back for additional documentation
Revised 06/09

5 Year Visit / Kindergarten Check-up



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Height _____ in. BMI _____ %tile B/P _____ Temp. _____ T R O

Interval History/New Problems

Changes in family history*? No Yes

Dyslipidemia Risk Assessment

FH heart disease < 55 No Yes
FH ↑ cholesterol No Yes

Are there any new problems or illnesses since the last visit?

No Yes _____

Nutrition

Appetite: good variable picky
Water: city well spring bottled
fluoridated
WIC: Yes No

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development, learning or behavior?

No Yes _____

Developmental / Behavioral Screening* (if clinically indicated)

Normal Abnormal

Hearing/Speech

Problems with speech? yes no

Hearing screening test :

referred not referred unable to test

Vision

L near 20/_____ far 20/_____

R near 20/_____ far 20/_____
muscle balance pass fail

Lead Risk Assessment* — +

TB Risk Assessment* — +

Anemia Risk Assessment — +

Lab Tests

Cholesterol (if at risk) _____

* see separate form

Physical Exam

	undressed	yes	no	√ = nl	X = abnl
General		<input type="checkbox"/>			
Head		<input type="checkbox"/>			
Neck		<input type="checkbox"/>			
Eyes		<input type="checkbox"/>			
Red Reflex		<input type="checkbox"/>			
Alignment		<input type="checkbox"/>			
Ears		<input type="checkbox"/>			
Nose		<input type="checkbox"/>			
Throat/Mouth/Teeth		<input type="checkbox"/>			
Lungs		<input type="checkbox"/>			
Heart		<input type="checkbox"/>			
Abdomen		<input type="checkbox"/>			
Femoral Pulses		<input type="checkbox"/>			
Genitalia					
Female	<input type="checkbox"/>				
Male	<input type="checkbox"/>				
Testes	<input type="checkbox"/>				
Extremities		<input type="checkbox"/>			
Gait		<input type="checkbox"/>			
Spine		<input type="checkbox"/>			
Skin		<input type="checkbox"/>			
Neuro		<input type="checkbox"/>			

Safety

- Booster seat > 40#, < 57" tall
- Bike helmet, street safety
- Smoke detectors
- No smoking in home
- Firearm safety
- Water safety, swimming lessons
- Outdoor safety, supervision
- Sunburn prevention

Health/Nutrition

- Low fat milk
- Encourage fruits and vegetables
- Brush teeth, see dentist
- Encourage active play

Social/Behavioral

- Give choices
- Encourage independence
- Praise good behavior
- Help child handle angry feelings and resolve conflicts with others
- Talk, time out, lose privileges
- TV limits, read to child
- Questions about sex
- Family relationships
- Friends and playmates
- Pre-school, school readiness

Impression

- Well Child
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- DTaP, IPV, MMR, Varicella
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Dental referral
- 5 year handout sheet
- RTC at _____ years

PROV # _____ M.D./ P.N.P.

See back for additional documentation

Revised 06/09

6 to 10 Year Visit



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs . Height _____ in. BMI _____ %tile BP _____ Temp. _____ T O

Interval History/New Problems

Changes in family history*? No Yes

Dyslipidemia Risk Assessment 6,8,10 yrs

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Are there any new problems or illnesses since the last visit?

No Yes _____

Nutrition

Low fat milk? yes no

Variety of fruits, vegetables? yes no

Eats breakfast? yes no

Eats supper with family? yes no

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development, learning or behavior?

No Yes _____

Developmental/Behavioral Screening*

(if clinically indicated)

Normal Abnormal

School Grade _____

Problems? yes no

Do you have any problems seeing or hearing? _____

Hearing (test at age 6, 8, 10 or every 2 yrs.)

Hearing screening test:

referred not referred

Date _____

Vision Risk Assessment — +

Vision (test at age 6, 8, 10 or every 2 years.)

L near 20/_____ far 20/_____

R near 20/_____ far 20/_____

Date _____

Wears glasses, sees eye specialist

TB Risk Assessment* — +

Lead Risk Assessment* (age 6) — +

Anemia Risk Assessment — +

* see separate form

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Neck

Eyes

Ears

Nose

Throat/Mouth/Teeth

Chest

Breasts/Tanner Stage

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia/Tanner Stage

Female Male

Extremities

Gait

Spine

Skin

Neuro

Safety

- Buckle up! Ride in back seat
- Booster seat < 57", < 8 years
- Bike helmet, street safety
- Smoke detectors
- No smoking in home
- Firearm safety
- Water safety, swimming lessons
- Sunburn prevention

Health/Nutrition

- Low fat milk and snacks
- Encourage fruits and vegetables
- Brush teeth, see dentist
- Adequate sleep
- Encourage sports, active play
- Sports form completed

Social/Behavioral

- School adjustment, performance
- Sports and hobbies
- Limit TV, computer games
- Give choices
- Encourage independence
- Set limits, provide consequences
- Parent supervises peer activities
- Privacy, personal hygiene
- Puberty changes and ? about sex
- Family relationships
- Friends and school
- Dealing with strangers

Impression

- Well Child
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- Dental referral at age 6
- RTC at _____ years

Handouts _____

_____, M.D./ P.N.P.

PROV # _____

See back for additional documentation

Revised 06/09

11 to 14 Year Visit



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Date _____

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs . Height _____ in. BMI _____ %tile BP _____ Temp. _____ T O

Interval History/New Problems

Changes in family history*? No Yes

Dyslipidemia Risk Assessment

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

Are there any new problems or illnesses since the last visit? No Yes

Nutrition

Low fat milk? yes no

Variety of fruits, vegetables? yes no

Eats breakfast? yes no

Eats supper with family? yes no

Developmental/Behavioral Surveillance

Do you have any concerns about your child's development, learning or behavior?

No Yes _____

School Grade _____

Problems? yes no

Developmental/Behavioral Screening*

(if clinically indicated)

normal abnormal

Do you have any problems seeing or hearing? _____

Hearing Risk Assessment — +

Vision Risk Assessment — +

Vision: test age 12, q 3 years or if + risk

L near 20/ _____ far 20/ _____

R near 20/ _____ far 20/ _____

o Wears glasses, sees eye specialist

TB Risk Assessment* — +

Anemia Risk Assessment — +

Alcohol/Drug use Assessment — +

STI Risk Assessment — +

Cervical Dysplasia Risk Assessment — +

* see separate form

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Neck

Eyes

Ears

Nose

Throat/Mouth/Teeth

Chest

Breasts/Tanner Stage

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia/Tanner Stage

Female Male

Extremities

Musculoskeletal Exam

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hips/thigh

Knee

Leg/ankle

Safety

- Smoke detectors
- No smoking in home
- Firearm safety
- Buckle up!
- Bike helmet, street safety
- Swimming, water safety
- Sunburn prevention

Health/Nutrition

- Low fat milk and snacks
- Healthy food choices
- Adequate sleep
- Brush teeth, see dentist
- Acne
- Encourage sports, exercise
- Sports form attached yes no

Social/Behavioral

- School adjustment, performance
- Sports and hobbies
- Limit TV, computer games
- Give choices
- Encourage independence
- Set limits, provide consequences
- Managing stress, anger
- Say no to alcohol, drugs, tobacco
- Puberty changes and ? about sex
- Periods (girls) LMP _____
- Family relationships
- Friends, boy/girl friends
- Abstinence, birth control

Impression

- Well Child/Adolescent
- Normal growth
- Normal development

Plan/Referrals

- Immunizations current yes no
- Tdap, MCV4, HPV
- Catch-up/at risk imm. _____
- Influenza vaccine
- V.I.S./Counseling
- RTC at _____ years
- Handouts _____

M.D./ P.N.P.

PROV # _____

- See back for additional documentation
- Revised 06/09

15 to 20 Year Visit

Tennessee Chapter of the

American Academy of Pediatrics

Tennessee Pediatric Society



Date _____

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____ lbs . Height _____ in. BMI _____ %tile BP _____ Temp. _____ T O

Interval History/New Problems

Changes in family history*? No Yes

Dyslipidemia risk Assessment

FH heart disease <55 No Yes

FH ↑ cholesterol No Yes

Fasting lipid profile once from 18-21 yrs.

Are there any new problems or illnesses since your last visit? No Yes

Nutrition

Low fat milk? yes no

Variety of fruits, vegetables? yes no

Eats breakfast? yes no

Eats supper with family? yes no

Developmental/Behavioral Surveillance

School Grade _____

Problems? yes no

Developmental/Behavioral Screening*

(if clinically indicated)

Normal Abnormal

Do you have any problems seeing or hearing? _____

Hearing Risk Assessment — +

Vision Risk Assessment — +

Vision (test at 15 & 18 or q 3 years)

L near 20/_____ far 20/_____

R near 20/_____ far 20/_____

o Wears glasses, sees eye specialist

TB Risk Assessment* — +

Anemia Risk Assessment — +

Alcohol/Drug Use Assessment — +

STI Risk Assessment — +

Cervical Dysplasia Risk Assessment — +

Physical Exam undressed : yes no √= nl X = abnl

General

Head

Neck

Eyes

Ears

Nose

Throat/Mouth/Teeth

Chest

Breasts/Tanner Stage

Lungs

Heart

Abdomen

Femoral Pulses

Genitalia/Tanner Stage

Female Male

Extremities

Spine

Skin

Neuro

Pelvic

(if age 19 or at risk)

Musculoskeletal Exam

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hips/thigh

Knee

Leg/ankle

Foot/toes

Safety

Driving and automobile safety

Bike safety, helmets

Smoke detectors

Swimming, water safety

Firearm safety

Sunburn prevention, tanning beds

Health/Nutrition

Healthy food choices, Ca++ intake

Concerns about wt., body image

Periods (girls) LMP _____

Adequate sleep

Acne

Encourage sports, exercise

Sports form attached yes no

Social/Behavioral

School adjustment, performance

Plans for work /further education

Tobacco use

Drug and alcohol use

Dealing with stress, anger

Limit TV, computer time

Friends and fun

Boy or girl friends

Abstinence, birth control

STDs

Family relationships

Impression

Well Adolescent

Normal growth

Normal development

Plan/Referrals

Immunizations current yes no

Tdap, MCV4, HPV

Catch-up/at risk imm. _____

Influenza vaccine

V.I.S./Counseling

RTC at _____ years

Handouts _____

M.D./ P.N.P.

PROV# _____

See back for additional documentation

Revised 06/09

*See separate form