

Visit signed by

MD on 08/08/12 3:18pm

2008 Bright Futures

Appointment Details

Appt Time: 08/08/12 2:20pm

Arrival Time: 08/08/12 2:01pm

Visit Reason: 9m_Appt_15min

Patient Age: 1 year

Location: Doctors Office

Provider:

Appt Note: 9m w/twin mom knows the policy for missed appts Rescheduled by
jaqui on 06/12/12 9:00am: was at: 06/13/12 9:15am, Dr.
9m, Office l/m on cell to call and confirm @ 9:56 by
08/07/2012

Perm H 3: A

Condition #2

12 month Well Child

Chart Example

12 Month Checkup**Others Present**☒ Assistant

, MD]

☒ Student

in Emory School of Medicine " " C. Catlich MD]

VitalsWeight 17 lbs 10.2 oz 4th percentile (8.000 kg)Length 28.5 in 25th percentile (72.39 cm)**Age at Visit**

1 yr []

Informant Full Name/Relationship

mother []

Current Medications

none []

Parent Concerns

none []

Social Hx

- ✓ Primary home/occupants
4 (2 adults 2 Kids) [
- ✓ Secondary home/occupants
- ✓ Primary caretaker / childcare
home

Health Risks

Yes No NA

- Immunocompromised?
- Pets?
- Tobacco exposure?
father smokes outside]
- Tb exposure?
- Lead exposure?
- Firearms?
- Car seat (rear facing)?
- Hip Dysplasia risk factors present?

Development (Leave Blank = Not Asked)

Yes No NA

- Sits well?
- Pulls to stand / cruises?
- Pincer grip?
- Imitates speech?
- Understands "no" and "bye"?
- Strangers / seperation anxiety?

- Full Developmental Screen (if indicated)
- Plays peek-a-boo?

Diet

- ✓ Cup
- ✓ Bottle
whole milk []
- ✓ Solids: Table Food?
in the process "

Elimination & Sleep

Abn NI N/A

- Urine
- Stooling
- Sleep

Physical Exam

Abn NI N/E

- Patient unclothed for exam? (A = clothed, N = unclothed)
- General
- Skin: No Jaundice/Good Turgor
- Head, Eyes, Ears, Nose and Throat
- Heart and Lungs
Heart: reg rhythm, no murmurs. Lungs: Easy WOB and clear ""
MD]
- Abdomen: No masses/No Hepatosplenomegaly

- Musculoskeletal
 - Hip Dysplasia Exam
Hips: creases and leg lengths equal, normal Galeazzi ' MD]
 - Genitalia
 - Neuro: Good tone
- Abn NI N/E**
- Hearing/Vision Grossly Intact

Diagnoses

- ✓ Well Child Care 29 Days-7 Yrs (V70.3)

Immunizations

VFC Varicella

Date: 08/08/12

Dose: 0.5 mL

Lot#: 0472AE

Mfr: Merck

Vis: 03/08 1

Vis Given: 08/08/12

Site: Lower Left Thigh

Administered by

Ordered by

TO:

Last Saved by ...

VFC MMR

Date: 08/08/12

Dose: 0.5 mL

Lot#: 1001AA

Mfr: Merck

Vis: 4/20/12 ...

Vis Given: 08/08/12

Site: Lower Right Thigh

Administered by

Ordered by

TO:

Last Saved by

VFC Hepatitis A (2 Dose)

Date: 08/08/12

Dose: 0.5 mL

Lot#: AHAVB605CA

Mfr: Glaxo Smith Kline

Vis: 10/2011

Vis Given: 08/08/12

Administered by

Ordered by

TO:

Last Saved by ...

Site: Left Thigh

VFC PCV13

Date: 08/08/12

Dose: 0.5 mL

Lot#: 917246

Mfr: Wyeth

Vis: 4/10, given by

Vis Given: 08/08/12

Site: Right Gluteal

Administered by

Ordered by

TO:

Last Saved by

Immunization Education/Counseling

Yes No N/A

- Counseling was provided for all vaccines administered today including disease processes, risk, benefits, and reactions of immunizations. VIMS were given and parental concerns and consent obtained.

VFC Eligibility Updates

✓ Medicaid Enrolled

Lab

HemaCue Completed

TO:

Last Saved by

Ordered by jackie

Facility: The Pediatric Center

Order Date: 08/08/12

Specimen Collected: By 08/08/12 12:45 PM

Results:

Hemoglobin: 14.3 g/dL (Normal: 11-14.5 g/dL) Interp: Normal

1 Task Completed

TASK: Collect Specimen

TO: j:

COMPLETED

Lead, Blood (Pediatric) Ordered

TO: quest

Last Saved by

Ordered by

Facility: Quest

Order Date: 08/08/12

Specimen Collected: By 08/08/12 12:45 PM

2 Tasks 1 Completed

TASK: Open Task

TO: _____

NOTE: blood drawn to be sent out to quest lab

COMPLETED []

TASK: Final Results Pending

TO: quest

Finger Prick Completed

TO:

Last Saved by

Ordered by

Facility: The Pediatric Center

Order Date: 08/08/12

Specimen Collected: By

08/08/12 12:46 PM

1 Task Completed

TASK: Complete Task

TO:

COMPLETED []

Anticipatory Guidance

Yes N/A/N/A

- Age Appropriate Handouts Given
Words of wisdom handout given [] MD]
- Nutrition: Change to Whole (Vit D) Milk, Drop in appetite normal, Encourage cup, ween off bottle by 18 months, Brush or wipe teeth daily
- Health/Safety: Drowning risks, Burns, Poison Control number-404-616-9000, Falls, Choking
- Psychosocial: Talk/Read to baby, Establish bedtime ritual, Teach body parts, Discipline-Distracting, substituting, consistency, reward good behavior, Temper Tantrums

Followup

Provide patient Visit Summary Completed

Ordered by

1 Task Completed

TASK: Complete Task

TO: frontoffice

NOTE: Visit Summary was given []

COMPLETED []

Schedule a Check-Up (indicate patient age and when needed)

Completed

Ordered by [redacted]

RESULT: 15 month with [redacted]

1 Task Completed



TASK: Appointment Needed

TO: frontoffice

NOTE: appt Scheduled on 11/26/12 @2:00pm with
DR [redacted]

COMPLETED [redacted]

Visit Documents

	Insurance/Billing (2 Pages) Note: Eligibility Verification [redacted] Attached to: 08/08/12 - 12 Month Checkup	Date: 08/08/12
	Demographics (1 Page) Note: ACA form [redacted] Attached to: 08/08/12 - 12 Month Checkup	Date: 08/08/12

The Pediatric Center
5405D Memorial Drive,
Stone Mountain, GA 30083-3236
(404) 296-3800

DOB: 07/23/11

Sex: Female

PCC #: 29789

Scheduled Visits:

11/26/2012 02:00pm 15m_Appt_20min

Date of Last Physical:

01/25/2012

Visit Summary for 08/08/2012

Doctors Office
12 Month Checkup

Diagnoses

Well Child Care 29 Days-7 Yrs (V70.3)

Vitals

Weight: 17 lbs 10.2 oz	(8.000 kg)	4th percentile
Length: 28.50 in	(72.39 cm)	25th percentile

Orders

Finger Prick
HemaCue

Hemoglobin:

Lead, Blood (Pediatric)

Provide patient Visit Summary

Schedule a Check-Up (indicate patient age and when needed)

Results

14.3 g/dL

15 month with anyone.

Immunizations:

VFC Hepatitis A (2 Dose)	Administered
VFC MMR	Administered
VFC PCV13	Administered
VFC Varicella	Administered

Patient Clinical Summary on 08/10/2012**Active Problems****Onset Date**

Newborn Twin

Polydactyly (Accessory Fingers)

Prematurity, 33-34 Completed Weeks

Gestation

Active Allergies

NKDA

Onset Date**Reaction****Current Medications**

hydroxyzine HCl (hydroxyzine hcl)

Formula

Syrup 10 mg/5 mL

Details

Take 2 ml by mouth three times a day as needed --for runny nose Dsp. 180 ml Rfls 3 (last 06/04/12 stop 10/02/12) by

Poly-Vi-Sol with Iron (pediatric multivitamin-iron)

Drops

Take 1 drop by mouth once a day as directed --1 dropperful by mouth daily. Dsp. 1 bottle Rfls 6 by MD

Immunizations:

DTaP-IPV-HIB

09/26/11, 11/28/11

VFC Pentacel

01/25/12

Hepatitis B Vaccine (3 Dose)

07/30/11, 09/26/11

VFC Hepatitis B (3 Dose)_

01/25/12

VFC PCV13

01/25/12, 08/08/12

VFC MMR

08/08/12

VFC Hepatitis A (2 Dose)

08/08/12

VFC Varicella

08/08/12

Rotavirus Vaccine

09/26/11, 11/28/11













































































































































































































































VFC Flu<36mo pres free

01/25/12

Prevnar

09/26/11, 11/28/11



Form	Infancy (Prenatal to 11 Months)							Early Childhood (1 to 4 Years)						Middle Childhood (5 to 10 Years)					Adolescence (11 to 21 Years)							
	Newborn	2-5 Day	1 Month	2 Month	4 Month	6 Month	9 Month	12 Month	15 Month	18 Month	2 Year	2½ Year	3 Year	4 Year	5 Year	6 Year	7 Year	8 Year	9 Year	10 Year	Introduction			11-14 Year	15-17 Year	18-21 Year
																						Older Child/Younger Adolescent	Early Adolescent	Middle Adolescent	Late Adolescent	
Previsit Questionnaire		 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 		
																					 	 	 	 	 	
Visit Documentation Form																										
Parent/Patient Education Handout		 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 		
																					 	 	 	 	 	
Supplemental Questionnaire		 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 	 		
																					 	 	 	 	 	
Medical Screening Questionnaire																										
Medical Screening Reference Table																										



Our system has converted these paper documents into a 12 month Well child protocol in electronic format.

Bright Futures Previsit Questionnaire 12 Month Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please answer all of the questions. Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support	<input type="checkbox"/> Ways to manage your child's behavior	<input type="checkbox"/> Finding time for yourself	<input type="checkbox"/> Parent/family community activities
Establishing Routines	<input type="checkbox"/> Nap time routines	<input type="checkbox"/> Bedtime routines	<input type="checkbox"/> Brushing teeth <input type="checkbox"/> Starting family traditions
Feeding Your Child	<input type="checkbox"/> Using a spoon and cup	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> How many meals or snacks a day <input type="checkbox"/> How much your child should eat <input type="checkbox"/> Change in appetite and growth <input type="checkbox"/> Your child's weight
Finding a Dentist	<input type="checkbox"/> Your child's first dental checkup	<input type="checkbox"/> Brushing teeth twice daily	<input type="checkbox"/> Finger sucking, pacifiers, and bottles
Safety	<input type="checkbox"/> Home safety indoors and outdoors	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Water safety <input type="checkbox"/> Gun safety <input type="checkbox"/> Older siblings watching your child <input type="checkbox"/> Foods that might cause choking

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: ☐ Yes ☐ No ☐ Unsure

Hearing	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Oral Health	Do you know a dentist to whom you can bring your child?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other problems?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes



Your Growing and Developing Child

Do you have specific concerns about your child's development, learning, or behavior? ☐ No ☐ Yes, describe:

Check off each of the tasks that your child is able to do.

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



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Bright Futures Parent Handout

12 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

Family Support

- Try not to hit, spank, or yell at your child.
- Keep rules for your child short and simple.
- Use short time-outs when your child is behaving poorly.
- Praise your child for good behavior.
- Distract your child with something he likes during bad behavior.
- Play with and read to your child often.
- Make sure everyone who cares for your child gives healthy foods, avoids sweets, and uses the same rules for discipline.
- Make sure places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends.

Establishing Routines

- Your child should have at least one nap. Space it to make sure your child is tired for bed.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Avoid having your child watch TV and videos, and never watch anything scary.
- Be aware that fear of strangers is normal and peaks at this age.
- Respect your child's fears and have strangers approach slowly.
- Avoid watching TV during family time.
- Start family traditions such as reading or going for a walk together.

Feeding Your Child

- Have your child eat during family mealtime.
- Be patient with your child as she learns to eat without help.
- Encourage your child to feed herself.
- Give 3 meals and 2–3 snacks spaced evenly over the day to avoid tantrums.
- Make sure caregivers follow the same ideas and routines for feeding.
- Use a small plate and cup for eating and drinking.
- Provide healthy foods for meals and snacks.
- Let your child decide what and how much to eat.
- End the feeding when the child stops eating.
- Avoid small, hard foods that can cause choking—nuts, popcorn, hot dogs, grapes, and hard, raw veggies.

Safety

- It is best to keep your child's car safety seat rear-facing until she reaches the seat's weight or height limit for rear-facing use. Do not switch your child to a forward-facing car safety seat until she is at least 1 year old and weighs at least 20 pounds. Most children can ride rear-facing for much longer than 12 months.
- Lock away poisons, medications, and lawn and cleaning supplies. Call Poison Help (1-800-222-1222) if your child eats nonfoods.
- Keep small objects, balloons, and plastic bags away from your child.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Lock away knives and scissors.

- Only leave your toddler with a mature adult.
- Near or in water, keep your child close enough to touch.
- Make sure to empty buckets, pools, and tubs when done.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.

Finding a Dentist

- Take your child for a first dental visit by 12 months.
- Brush your child's teeth twice each day.
- With water only, use a soft toothbrush.
- If using a bottle, offer only water.

What to Expect at Your Child's 15 Month Visit

We will talk about

- Your child's speech and feelings
- Getting a good night's sleep
- Keeping your home safe for your child
- Temper tantrums and discipline
- Caring for your child's teeth

Poison Help: 1-800-222-1222

Child safety seat inspection:

1-866-SEATCHECK; seatcheck.org



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Bright Futures Parent Supplemental Questionnaire 12 Month Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please circle Yes or No for each question. Thank you.

Family Support

Do you need help teaching your child good behavior?	No	Yes
Do you reward your child's good behavior?	Yes	No
When your child misbehaves, do you use brief time-outs (1–2 minutes)?	Yes	No
Do you try to distract your child when she misbehaves?	Yes	No
Do you discuss your ideas about your child's behavior and discipline with your child's caregivers?	Yes	No
Do you participate in activities through social, religious, volunteer, or recreational programs?	Yes	No
Do you talk with friends about parenting?	Yes	No
Do you go to playgroups?	Yes	No

Establishing Routines

Do you play with and read to your child every day?	Yes	No
Do you help your child feel comfortable around new people?	Yes	No
Does your child have regular mealtimes and snack times?	Yes	No
Do you have a regular bedtime routine for your child?	Yes	No
Does your child play actively for one hour or more a day?	Yes	No
How many hours per day does your child watch TV?	_____ hours	

Feeding Your Child: Feeding and Appetite Changes

Do you give your child small, hard foods like peanuts or popcorn?	No	Yes
Do you give your child round foods such as hot dogs, raw carrots, or grapes?	No	Yes
Does your child try feeding himself using a spoon or fork?	Yes	No
Do you let your child decide what and how much to eat?	Yes	No

ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE		DATE/TIME		Name	
DRUG ALLERGIES			CURRENT MEDICATIONS			ID NUMBER	
WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	BIRTH DATE	AGE	
See growth chart.						M F	

History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Child has special health care needs
<input type="checkbox"/> Child has a dental home	

Concerns and questions ☐ None ☐ Addressed (see other side)

Follow-up on previous concerns ☐ None ☐ Addressed (see other side)

Interval history ☐ None ☐ Addressed (see other side)

☐ Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Family situation

Parents working outside home: ☐ Mother ☐ Father

Child care: ☐ Yes ☐ No Type _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

☐ No interval change

Changes since last visit _____

Nutrition: ☐ Breast milk Minutes per feeding _____

Hours between feeding _____ Feedings per 24 hours _____

☐ Formula Ounces per feeding _____

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

Physical Examination

☒ NL

Bright Futures Priority

☐ EYES (red reflex, cover/uncover test)

☐ NEUROLOGIC (tone, strength, gait)

☐ TEETH (caries, white spots, staining)

☐ GENITALIA

☐ MALE/TESTES DOWN

☐ FEMALE

Additional Systems

☐ GENERAL APPEARANCE

☐ HEAD/FONTANELLE

☐ EARS/APPEARS TO HEAR

☐ NOSE

☐ MOUTH AND THROAT

☐ HEART

☐ Femoral pulses

☐ EXTREMITIES/HIPS

☐ LUNGS

☐ ABDOMEN

☐ BACK

☐ SKIN

Abnormal findings and comments _____

Assessment

☐ Well child

Anticipatory Guidance

☐ Discussed and/or handout given

☐ FAMILY SUPPORT

• Time for self/partner

• Community activities

• Age-appropriate discipline

☐ ESTABLISHING ROUTINES

• Family traditions

• Nap and bedtime

☐ FEEDING AND APPETITE

CHANGES

• Self-feeding

• Consistent meals/snacks

• Variety of nutritious foods

• Iron-fortified formula

☐ ESTABLISHING A DENTAL HOME

• First dentist visit

• Brush teeth twice a day

• Limit bottle use (water only)

• No bottle in bed

☐ SAFETY

• Car safety seat

• Poisons

• Water

• No supervision by young children

• Sharp objects

• Guns

• Home safety

• Falls

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: ☐ Hgb/Hct ☐ Lead Other _____

☐ Referral to _____

Follow-up/Next visit _____

☐ See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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Finding a Dentist: Establishing a Dental Home

Have you taken your child to a dentist?	Yes	No
Do you brush your child's teeth with water 2 times a day, using a soft toothbrush?	Yes	No
Does your child use a bottle?	No	Yes

Safety

Do you always use a car safety seat rear-facing in the back seat of all vehicles?		Yes	No
Are you having any problems with your car safety seat?		No	Yes
Do you know when to turn your child's car safety seat forward?		Yes	No
Do you keep cleaners and medicines locked up?		Yes	No
Do you have a gate on your stairs?		Yes	No
Are you able to lock your windows?		Yes	No
Can your child climb out of her crib?		No	Yes
Is your child's crib on the lowest setting?		Yes	No
Do you stay within arm's reach when your child is in the bathtub?		Yes	No
Do you have a swimming pool, pond, or lake in or near your home?		No	Yes
Does anyone in your home or the homes where your child spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away?	N/A	Yes	No
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No



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Bright Futures Medical Screening Questionnaire

12 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child speaks?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Does your child hold objects close when trying to focus?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Do you know a dentist to whom you can bring your child?	N	Y	Unsure
Does your child's primary water source contain fluoride?	N	Y	Unsure



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Visit signed by

MD on 07/29/12 8:21pm

PCMH 3A

Appointment Details

Appt Time: 07/26/12 4:30pm

Arrival Time: 07/26/12 4:34pm

Visit Reason: ADHD Initial Eval_30min

Patient Age: 9 yrs, 6 mos

Location: Doctors Office

Provider: , MD

Appt Note: new pt

Condition #3
ADHD Chart ExampleGuidelines: AAP's Clinical
Practice Guideline ADHD**ADHD Consult****Informant Full Name/Relationship**

Mother [,]

Vitals

Temperature 98 °F Temporal

Pulse 93 bpm

Resp Rate 21 bpm

Blood Pressure 93/55 s/d Loc.: Left Arm Pos.: Sitting

Height 53.75 in 51st percentile (136.52 cm)Weight 63 lbs 8 oz 38th percentile (28.803 kg)BMI 15.5 kg/m² 30th percentile Height 53.75 in Weight 63 lbs 8 oz**Current Grade Level In School (include name of school)**

4th E. L. [,]

Smoking Status (ARRA)

Never Smoker [,]

Referred by

Internet [,]

Transition of Care: Current ADHD Medications

Concerta

36 Mg. prescribed by Dr.

in Valdosta, GA.

, MD]

Transition of Care