Patient Label

Today's Date: _____ / _____/ _____ **Age:** _______ **Family Doctor:** _________________________ ❑**LEP: Interpreter** ________________

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PATIENT:

What is the main reason for the patient's visit today?

Is the patient having any problems or symptoms today that you would like to discuss? ❑ yes ❑ no
If you answered yes, please briefly explain:

Is the patient allergic to any medicines or foods? ❑ yes ❑ no
If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:

Patient's current medications (*Prescription / Over the counter)*: ❑ None ❑ Multivitamins ❑ Folic Acid ❑ Calcium ❑ Birth Control
❑ Other:

Since the patient's last visit, has the patient had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ no
If you answered yes, please briefly explain:

Since patient's last visit, have there been major **health** changes for the following:❑Patient (child) ❑Parent ❑Sister/Brother ❑Child ❑Grandparent
Please describe any changes:

Since patient's last visit, please check if you had changes in the following: ❑Educational Status ❑Employment ❑Marital status ❑Living conditions
Please describe any changes:

Nutrition: check foods you eat every day ❑Milk / Dairy ❑Meats ❑Vegetables ❑Fruits ❑Breads or Grains	**Do you have concerns about the child's weight?** ❑Yes ❑No	**Exercise** ❑ None ❑ Seldom ❑ Occasional ❑ Frequent
Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff) ❑Never used ❑ Exposed to smoke ❑ Past user: type __________________________ ❑Use now: type____________________________ (# per day ____________)	**Alcohol or Street Drugs** ❑None ❑ Seldom: type______________________ ❑Occasional: type____________________ ❑Frequent : type_____________________	**Mental Health**: (*in past 90 days)* ❑No Problem ❑Mild/Moderate Depression ❑Severe Depression ❑ Thoughts of harming self / others
Dental Health ❑Brush daily ❑Floss daily ❑Visit dentist every 6 months	**Water Source:** ❑ Well ❑ Cistern ❑ Bottled ❑ City	**Travel:** ❑No travel outside USA ❑Traveled outside USA: Country/Year________________/_____
Abuse / Neglect / Violence: ❑ No fear of harm ❑Pressure to have sex ❑Daily needs not met ❑Forced sexual contact ❑Fear of verbal/physical abuse	**Sexually Active:** ❑Yes ❑No Birth Control Method: **Male patients only:** Does the patient examine his testicles every month? ❑Yes ❑No	**Female patient only:** Do you examine your breasts every month? ❑Yes ❑No First day of last menstrual period:___/___/___

Developmental Assessment: Choose your (the patient's) age below and check tasks achieved.

1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months
❑Equal movements ❑Lifts head ❑Responds to sound ❑Regards face ❑Smiles	❑Hands together / Reach ❑Squeals ❑Bears leg weight ❑Rolls over ❑Turns to sound	❑Sits without support ❑Looks for object ❑Stands holding on ❑ "Mama" or "Dada" ❑Pulls to stand	❑Combines syllables: "dadadada" ❑Thumb finger grasp ❑Claps hands ❑Stands – 5 seconds	❑Stands alone or walks ❑Stoops / Recovers ❑Plays ball / Scribbles ❑Drinks from cup ❑Knows 3 words	❑Uses spoon / fork ❑Runs / Kicks ball ❑Stacks 3 blocks ❑Knows 6 words ❑Removes garment
2-3 years	**4-5 years**	**6-7 years**	**8-10 years**	**11-15 years**	**16-21 years**
❑Combines words ❑Names pictures / color ❑Jumps up ❑Puts on clothing ❑Wash / dry hands ❑Names friend	❑Speaks clearly ❑Hops on one foot ❑Dresses, no help ❑Brushes teeth, no help ❑Copies + ❑Draws person	❑Heel to toe steps ❑Knows alphabet ❑Counts ❑Knows right vs. wrong ❑Prints letter	❑Same sex friends ❑Aware of outside world ❑Builds self-confidence ❑Seeks independence ❑Peer influence	❑Seeks privacy ❑Takes some risks ❑Same sex friends ❑Different sex friends ❑Understands rules ❑Good self-image	❑Self Confidence ❑Friends important ❑Less time with family ❑Thoughts of future ❑Questions rules ❑Sexual identity

Patient/ Caregiver Signature: **Date:**

TO BE COMPLETED BY HEALTHCARE PROVIDER

Immunization Status: ❑ Up to date by patient report ❑ Records Requested
❑ See Vaccine Administration Record ❑ Vaccines given today

Lead Assessment: Verbal Risk Assessment: ❑ neg ❑ pos ❑N/A
Tested Today: ❑ yes ❑ no Referred for testing: ❑ yes ❑ no

Preventive Health Education: **topics discussed today**
❑ Child development
❑ Immunizations
❑ Dental
❑ Hearing/Vision
❑ Lead exposure(ACH-25a)
❑ Diet / Nutrition
❑ Physical activity
❑ Safety
❑ Mental Health
❑ DV/SA
❑ ATOD/Cessation/SHS
❑ Diabetes
❑ Preconception /Folic Acid
❑ Prenatal / Genetics
❑ CVD
❑ Arthritis
❑ Osteoporosis
❑ Cancer
❑ Pelvic / Pap
❑ SBE /Mammogram
❑ STE / PSA
❑ HRT
❑ STD / HIV
❑ Minor FP: Sexual coercion. Abstinence. Benefits of parental involvement in choices.
❑ Options counseling

Educational Handouts:
❑ Age-appropriate Points to Remember
❑FPEM ❑PTEM ❑CSEM
❑ Other:

Patient verbalizes understanding of education given ❑

Healthcare Provider Signature: **Date:**

Patient Label

SUBJECTIVE / PRESENTING PROBLEM:

OBJECTIVE: **General Multi-System Examination**

SYSTEM		NL	ABNORMAL
Constitutional	General appearance		
	Nutritional status		
	Vital signs		
HEENT	Head: Fontanels, Scalp		
	Eyes: PERRL		
	Conjunctivae, lids		
	Ear: Canals, Drums		
	Hearing		
	Nose: Mucosa / Septum		
	Mouth: Lips, Palate		
	Teeth, Gums		
	Throat: Tonsils		
Neck	Overall appearance		
	Thyroid		
Respiratory	Respiratory effort		
	Lungs		
Cardiovascular	Heart		
	Femoral / Pedal pulses		
	Extremities		
Chest	Thorax		
	Nipples		
	Breasts		
Gastrointestinal	Abdomen		
	Liver / Spleen		
	Anus / Perineum		
Genitourinary	Male: Scrotum		
	Testes		
	Penis		
	Prostate		
	Female:Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		

FRONT

BACK

SYSTEM		NL	ABNORMAL
Lymphatic	Neck, Axilla, Groin		
Musculoskeletal	Spine		
	ROM		
	Symmetry		
Skin / SQ Tissue	Inspection(rashes)		
	Palpation (nodules)		
Neurological	Reflexes		
	Sensation		
Psychiatric	Orientation		
	Mood / Affect		

Tanner Stage: ❑ typical ❑ atypical

X-Ray*:* Type: Result: ❑No Change
Date taken: ❑Neg/Non-remarkable
Date read: ❑Improved
Date compared with: ❑Worsening

TB Classification: ❑ TB suspect
❑0 No TB exposure, not infected
❑I TB exposure, no evidence of infection
❑II TB infection, without disease
❑III TB, clinically active
❑IV TB, not clinically active
Site of infection: ❑Pulmonary __Cavity __Non Cavity ❑ Other:

EXPLANATION OF ABNORMAL FINDINGS:

ASSESSMENT:

PLAN:

Testing today*:* ❑ N/A
❑ GC ❑ Chlamydia
❑ UA ❑ TST
❑ VDRL ❑ HIV
❑ Pap ❑Lead
❑ Hgb ❑ Cholesterol
❑ Blood Glucose
❑ Urine PT / UCG: ❑Pos ❑Neg
Planned pregnancy? ❑ Yes ❑ No
❑Other:

Medications: ❑ N/A
❑ MV / Folic Acid
# of bottles given ______
❑ Fluoride varnish applied
❑ Fluoride drops
❑ Other:

Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment: ❑ N/A
❑ Vision / Hearing ❑ FBS / GTT
❑ Speech ❑ Lipid Screen
❑ Dental ❑ Pap Smear
❑ Hgb ❑ Mammogram
❑ Sickle Cell ❑ Ultrasound
❑ Lead ❑ TST / CXR
❑ UCG / HCG ❑ Liver Panel
❑ Developmental Scr. Tests
❑ Other:

Referrals made: ❑ N/A
❑ PMD ❑ HANDS
❑ Pediatrician ❑ WIC
❑ Specialist: ❑ Dental
❑ Radiology ❑ FP
❑ MNT with RD ❑ STD
❑ Medicaid
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Cooper Clayton Classes
❑ Other:

Healthcare Provider Signature: **Date:** **Recommended RTC: Well-child exam**___________________

Immunizations___________________

Other: ____