PEDIATRIC INITIAL HISTORY AND PHYSICAL

Today's Date:_____/_____/ _____ **Age:** _____ **Primary Care Provider:** _____ ☐**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:

List Current Medications (*Prescription / Over the counter)*: ❑ None

Has the patient had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ no
If you answered yes, please briefly explain:

Patient's Living Conditions: ❑ Alone ❑ With family: # of children in home_____ ❑ With Roommate ❑ In group or foster home

Patient's Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Patient's Education: ❑ N/A❑ Current Student: Grade: _____
School_____
Highest education level completed: _____

Employment: ❑ Not employed ❑ Place of employment: _____
Name of Childcare: _____
Other childcare provider (grandma etc.) _____

Please check if the patient has or had any of the following: **❑ No Current problems**

❑ COVID-19 Diagnosis confirmed by: ❑ Rapid ❑ PCR DATE: _____

Travel: ❑ No travel ❑Outside USA, where and when? _____❑Travel outside KY, where and when? _____

CONSTITUTIONAL
- ❑ Fatigue
- ❑ Difficulty sleeping
- ❑ Fever/chills
- ❑ Night sweats
- ❑ Recent weight change

EYES
- ❑Blurred or double vision
- ❑Dryness / Redness
- ❑ Wear glasses or contacts
- ❑ Cataracts
- ❑ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ❑Earaches or drainage
- ❑Ringing in the ears
- ❑Hearing loss
- ❑Sinus infections/problems
- ❑Nosebleeds
- ❑Frequent sore throat
- ❑Dryness of the mouth
- ❑Bad breath/bad taste
- ❑Mouth sores/ulcers
- ❑Voice changes
- ❑Bleeding gums
- ❑Difficulty swallowing
- ❑Dentures

HEAD, FACE, NECK
- ❑ Headaches
- ❑ Reduced facial strength
- ❑ Recent hair loss
- ❑ Scalp tenderness
- ❑ Swollen glands in the neck

CHEST/BREAST
- ❑ Breast discharge
- ❑ Breast lump
- ❑ Breast pain
- ❑ Breast implants

GASTROINTESTINAL
- ❑ Heartburn or indigestion
- ❑ Loss of appetite
- ❑ Abdominal pain
- ❑ Changes in bowel habits
- ❑ Painful bowel movements
- ❑ Constipation
- ❑ Frequent diarrhea
- ❑ Hemorrhoids/blood in stool
- ❑ Nausea or vomiting
- ❑ Abnormal liver tests/ liver disease

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Excessive thirst
- ❑ Change in tolerance to hot/cold weather

CARDIOVASCULAR
- ❑ Angina or heart attack
- ❑ Chest pain or pressure
- ❑ Fast or irregular heart beat
- ❑ Swelling of feet / ankles
- ❑ Poor circulation
- ❑ Blood clots
- ❑ High blood pressure

GENITOURINARY
- ❑ Burning or painful urination
- ❑ Blood or pus in urine
- ❑ Incontinence or dribbling
- ❑ Vaginal discharge
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Prostate problems
- ❑ Testicular pain
- ❑ Sexual difficulty
- ❑ Genital rash or ulcers

SKIN
- ❑ Rash or itching
- ❑ Change in moles
- ❑ Change in skin color
- ❑ Psoriasis
- ❑ Skin nodules or bumps
- ❑ Easy bruising
- ❑ Sores that won't heal

RESPIRATORY
- ❑Asthma or Wheezing
- ❑ Difficulty breathing
- ❑ Cough with mucous production
- ❑ Chronic or frequent coughs
- ❑ Dry cough
- ❑ Pain on breathing
- ❑ Spitting/coughing blood

MUSCULOSKELETAL
- ❑ Back pain
- ❑ Cold extremities
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Walk with assistive device
- ❑ Difficulty climbing stairs

NEUROLOGICAL / PSYCHIATRIC
- ❑Convulsions or seizures
- ❑Tremors
- ❑Memory loss or confusion
- ❑Light headed/ Dizziness
- ❑Loss of consciousness
- ❑Stroke
- ❑ Depression

Please ✓ those that apply to the patient or the patient's blood relatives.

	Patient	Parent	Brother/Sister	Grandparent	Child
HIV/AIDS					
Alcohol / Drug Addiction					
Alzheimer's					
Arthritis					
Asthma					
Birth Defects					
Bleeding Disorder / Free Bleeder					
Cancer					
COPD / Emphysema / Chronic Bronchitis					
Diabetes					
Epilepsy / Convulsions / Seizures					
Heart Attack / Stroke					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease / Hepatitis					
Mental Illness / Depression					
Osteoporosis					
Sickle Cell					
Thyroid Disorder					
Tuberculosis/TB					
Other:					

Nutrition: check foods you eat every day
❑Milk / Dairy ❑Meats ❑Vegetables
❑Fruits ❑Breads or Grains

Do you have concerns about the patient's weight?
❑Yes ❑No

Exercise
❑ None ❑ Daily (1 hour)
❑ 2-3x week ❑ weekly

Tobacco Use/ Smoke Exposure (E-cigs, cigarettes, cigars, pipe, dip, chew)
❑Never used ❑ Exposed to smoke
❑ Past user: type _____ How long was it used?_____
❑Use now: type_____
(# per day_____)

Alcohol or Substance Use (marijuana, opioids, heroin, meth, etc.)
❑None
❑ Type_____
❑How often? _____

Mental Health: (*in past 90 days)*
❑No Problem
❑Mild/Moderate Depression/Anxiety
❑Severe Depression/Anxiety
❑ Thoughts of harming self / others
❑Other mental health concerns
_____

Dental Health: ❑Brush daily ❑Floss daily
Dental visit: ❑ every 6 months or ❑ yearly

Water Source:
❑ Well ❑ Cistern
❑ Bottled ❑ City

Abuse / Neglect / Violence: ❑ No fear of harm ❑Pressure to have sex ❑Daily needs not met ❑Forced sexual contact ❑Exploitation ❑Fear of verbal/physical abuse ❑Sex for money or drugs

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: **Healthcare Provider Signature:** **Date:**

TO BE COMPLETED BY HEALTHCARE PROVIDER

Only for patients ages 0-5 years

Mother's general health during pregnancy:
❑Excellent ❑Good ❑ Fair ❑ Poor
At time of delivery, did mother have HIV: ❑ yes ❑ no
Hepatitis: ❑ yes ❑no
Explain any problems:

During pregnancy did mother:
Smoke ❑ yes ❑ no
Drink alcohol ❑ yes ❑ no
Substance Use ❑ yes ❑ no
TYPE:

Birth Information
Delivery: ❑ vaginal ❑ cesarean
If cesarean, explain why:
Weeks gestation:
Birth weight:

Home with mom from hospital: ❑ yes ❑ no
If no, explain why not:

Metabolic/CCHD Screen completed: ❑ yes ❑ no
Results reviewed ❑ yes **Requested** ❑ yes

Initial feeding at birth: ❑ bottle ❑ breast
Is this child breastfeeding now: ❑ yes ❑ no
feedings in 24 hours:
Explain any problems:

Is this child bottle feeding: ❑ yes ❑ no
What formula?
Ounces in 24 hours:
in any problems:

Caretaker concerned about any of the following:
Emotional development ❑ yes ❑ no
Attention span ❑ yes ❑ no
Behavior ❑ yes ❑ no
Academics ❑ N/A ❑ yes ❑ no
Neglect ❑ yes ❑ no

Has this child had any of the following diseases:

COVID-19	❑ yes	❑ no
Measles	❑ yes	❑ no
Mumps	❑ yes	❑ no
Rubella	❑ yes	❑ no
Chickenpox	❑ yes	❑ no
Meningitis	❑ yes	❑ no
Rotavirus	❑ yes	❑ no
Pneumonia	❑ yes	❑ no
Pertussis	❑ yes	❑ no
Hib	❑ yes	❑ no
Hepatitis	❑ yes	❑ no
RSV	❑ yes	❑ no

(Girls) Age menstruation onset:_____❑ NA
LMP:_____/_____/_____
Does pt examine breasts monthly? ❑ yes ❑ no

If sexually active, # of partners: lifetime_____Last 60 days_____Last 30 days _____
Birth control used: ❑ yes ❑ no Type:

Other health concerns:

Frequent problems with any of the following:

Nasal infections	❑ yes	❑ no
Ear Infections	❑ yes	❑ no
Throat infections	❑ yes	❑ no
Asthma attacks	❑ yes	❑ no
Constipation	❑ yes	❑ no
Diarrhea	❑ yes	❑ no
Urinary tract infections	❑ yes	❑ no
Bedwetting	❑ yes	❑ no
Swallowing	❑ yes	❑ no
Vomiting	❑ yes	❑ no
Refusal to eat	❑ yes	❑ no
Headaches	❑ yes	❑ no
Vision	❑ yes	❑ no
Hearing	❑ yes	❑ no
Bleeding	❑ yes	❑ no

Other: _____
_____
_

(Boys) Does patient examine testicles monthly?
❑ yes ❑ no

Immunization Status: ❑ Up to date by patient report ❑ Vaccines given today:_____
_____ ❑ VIS reviewed with parent/guardian and signed
❑ Records Requested: PCP_____ KYIR _____School_____ Date: _____ ❑ See Vaccine Administration Record

Lead Assessment: Verbal Risk Assessment: ❑N/A ❑ negative ❑ positive risk factor_____
Tested Today: ❑ yes ❑ no Referred for testing: ❑ yes ❑ no

Preventive Health Education:
topics discussed today

- ❑ Child development
- ❑ Immunizations/VIS
- ❑ 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 (or caretaker) verbalizes understanding of education given ❑

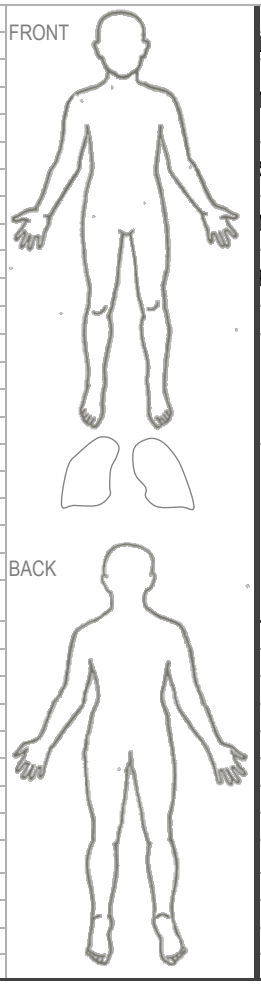
ADDITIONAL NOTES:

Healthcare Provider Signature: **Date:**

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		



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
❑ Fluoride varnish applied
❑ Fluoride drops ordered
❑ MVI / Folic Acid
# of bottles given _____
❑ Other:

Recommendations made to client, for scheduling of possible 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
❑ PCP/Medical Home_____
❑ Specialist:_____
❑ HANDS ❑ WIC
❑ Dental ❑ MNT with RD
❑ Radiology ❑ Family Planning
❑ STD
❑ Medicaid
❑ Social Services
❑ Smoking Cessation
❑ Other:

Healthcare Provider Signature: **Date:** **Recommended RTC: Well-child exam**_____
Immunizations_____
Other: _____