Patient Label

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

Since the patient's last visit, has the patient had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ noIf 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 ❑ Daily (1 hour) ❑ 2-3x week ❑ Weekly
Tobacco Use/ Smoke (E-cigs, cigarettes, cigars, pipe, dip, chew)pipe, dip,chew) ❑Never used ❑ Exposed to smoke ❑ Past user: type_____________ How long 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	**Travel:** ❑ No travel ❑Outside USA, where and when? ______________________________ ❑Travel outside KY, where and when? ______________________________
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 have a monthly menstrual period? ❑Yes ❑No First day of last menstrual period:___/___/_ Do you examine yourbreasts every month? ❑Yes ❑No

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

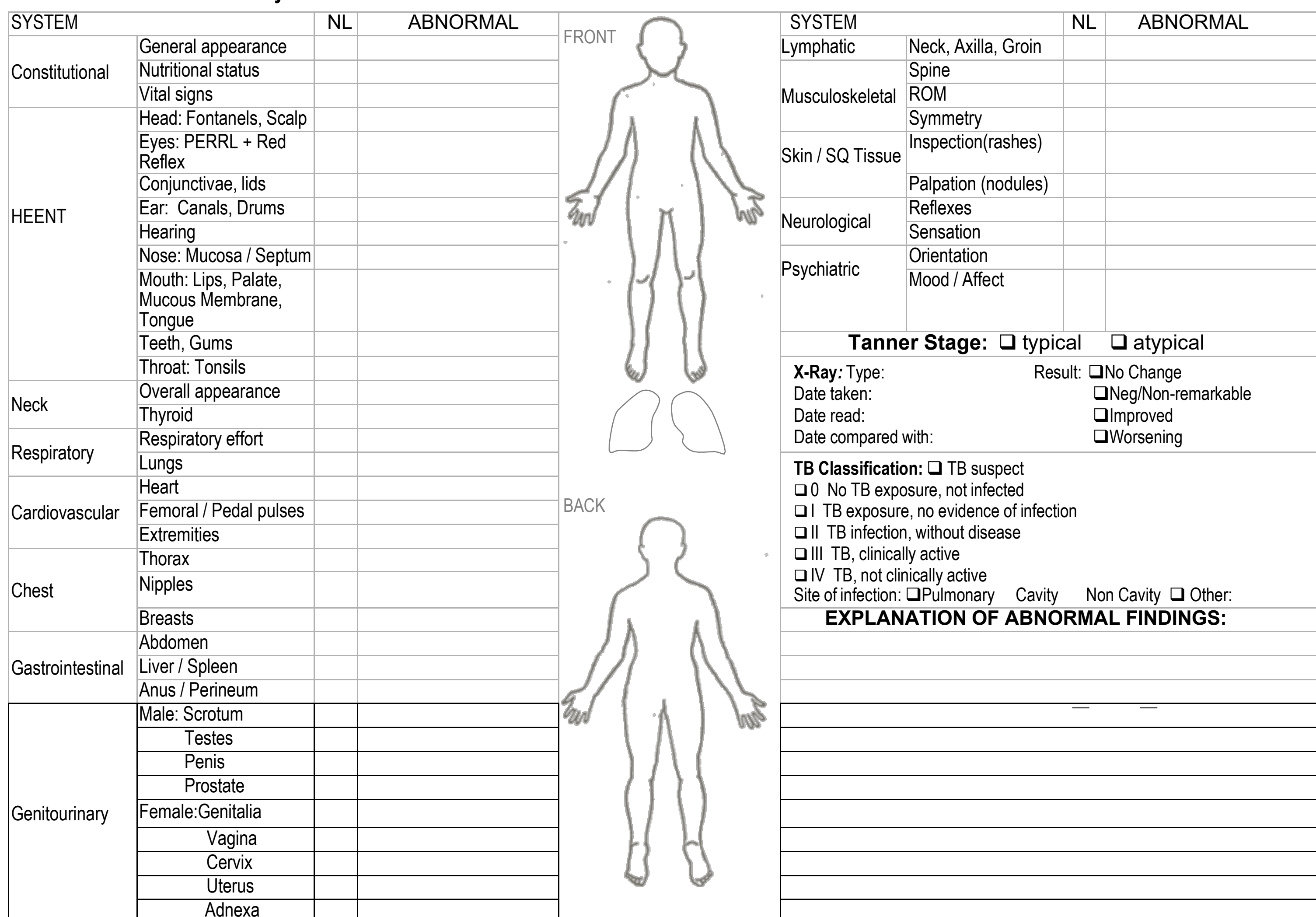
Immunization Status: ❑ Up to date by patient report ❑ Vaccines given today:____ ____ ______________❑ VIS reviewed with parent/guardian and signed ❑ Records Requested: PCP__________ KYIR _________School_____________ Date: ___________ ❑ See Vaccine Administration Record ❑	**Lead Assessment:** Verbal Risk Assessment: ❑ neg ❑ pos ❑N/A Tested Today: ❑ yes ❑ no Referred for venous testing: ❑ yes ❑ no

Preventive Health Education: <u>**topics discussed today**</u> ❑ 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 (FP/BC) counseling	**Educational Handouts:** ❑ Age-appropriate Points to Remember ❑FPEM ❑PTEM ❑CSEM ❑ Other: **Patient verbalizes understanding of education given** ❑

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 + Red Reflex		
	Conjunctivae, lids		
	Ear: Canals, Drums		
	Hearing		
	Nose: Mucosa / Septum		
	Mouth: Lips, Palate, Mucous Membrane, Tongue		
	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:

Patient Label

ASSESSMENT:
PLAN:

Testing today: ❑ N/A	**Medications:** ❑ N/A	**Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment:**	**Referrals made:** ❑ N/A
❑ GC ❑ Chlamydia ❑ UA ❑ TST ❑ VDRL ❑ HIV ❑ Pap ❑Lead ❑ Hgb ❑ Cholesterol ❑ Blood Glucose ❑ Urine PT / UCG: ❑Pos ❑Neg Planned pregnancy? ❑ Yes ❑ No ❑Hearing Screen ❑Vision Screen ❑Other:	❑ Fluoride varnish applied ❑ Fluoride drops ordered ❑ MVI/Folic Acid # of bottles given ____ ❑ Other:	❑ 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:	❑ PCP/Medical Home_______________ ❑ Specialist: ____________________ ❑ HANDS ❑ WIC ❑ Dental ❑ Family Planning ❑ Radiology ❑ STD ❑ MNT with RD ❑ Medicaid ❑ Social Services ❑ Smoking Cessation ❑ Other:

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

Immunizations___________________

Other: ____