Today's Date:_____

Patient Name:	FMP and Sponsor SSN last four:	Contact Number: Date of Birth:

7-8 YEAR WELL CHECK

Do you have any specific concerns today?_____

_____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medications (PLEASE INCLUDE DOSAGE)
		Allergies **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):**

Please list any known allergies your child has (drug, food, latex)_____ ☐ No Allergies

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness before age 5 Birth Defects Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Are your child's immunizations up to date? ☐ Yes ☐ No

Who does the child live with? _____

Does your child attend: ☐ Child care ☐ Public/ Private school ☐ Home- Schooled (Grade:_____)

Does anyone in the family smoke or is your child exposed to secondhand smoke? ☐ Yes ☐ No

Do you & and your child feel safe at home? ☐ Yes ☐ No

Is your child a picky eater? ☐ Yes ☐ No **Servings of fruits and vegetables per day?___ # of times per week eating fast food?____**

Usually eats dinner as a family? ☐ Yes ☐ No **Eats breakfast as a family?** ☐ Yes ☐ No

Drinks milk? ☐ Yes ☐ No **How many ounces per day? ____ Type of milk:** ☐ Whole ☐ 2% ☐ 1% ☐ Skim

Drinks juice? ☐ Yes ☐ No **How many ounces per day? ____ Caffeinated beverages?** ☐ Yes ☐ No **How many per week? ____**

Does your child get at least one hour of physical activity 5 time per week? ☐ Yes ☐ No **Type of activity: _____**

How many hours of exposure to TV/Video games/ Computer time does your child have per day? _____

Circle if you have concerns about: Bowel movements / Constipation / Sleep problems

Check all the following that apply to your child:

Social/ Cognitive Communicative/ Physical Development	
☐ Does chores at home when asked	☐ Reading and doing math at grade level
☐ Gets along with family and friends	☐ Eating healthy food and snacks
☐ Engages in after school activities	☐ Has a positive self-image

Check if your child has a history of: ☐ Trauma ☐ Head trauma ☐ Concussion ☐ Fractures ☐ Chest pain or discomfort ☐ Fainting during exercise ☐ Exercise intolerance ☐ Palpitations

Pre-Teen/ Females only (if applicable): Last menstrual period _____

Has your child been seen by a provider outside of the Medical home clinic since your last visit? ☐ Yes ☐ No

If yes, where? _____

Preferred Language: ☐ English ☐ Other:_____

What is your preferred method of learning: ☐ Verbal ☐ Written ☐Visual ☐ Other: _____

Are there any cultural or religious considerations that may affect your child's healthcare? ☐ Yes ☐ No _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/ Q-coded)? ☐ Yes ☐ No

Is the child's sponsor currently deployed? ☐ Yes ☐ No

Is this visit deployment related? ☐Yes ☐ No

Today's Date:_____

HT		Snellen	
WT		R	___/ 20
BP		L	___/ 20
HR		Both	___/ 20

Pain: □ Yes □ No **Location of Pain _____**

Immunizations UTD per AFCITA: □ Yes □ No **Technician Signature:_____**

*Other VS per Provider request

HPI:

N E	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT/Nontender/FROM	□
□	**Eyes:**	□ RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, no lumbosacral pits	□
□	**Skin:**	□ No rash, No bruises	□
□	**Hips:**	□ Full ROM, Symmetric leg folds	□
□	**Neuro:**	□ Normal tone/strength/symmetry	□
□	**Genitalia:**	□ Nl female/no adhesions □ Nl male, Testes down	
□	**Other findings:**	□	□

LABS/X-RAYS: □ H&H (12 months): □ Lead Screening (if applicable)

PLAN:

F/U: at next well child visit at___months, sooner if parental concerns
□ Patient and/or parent verbalizes understanding of treatment and plan □ Anticipatory guidance handout provided

PREVENTION: □ Nutrition □ Dental care □ Safety/Falls □ Car Seat □ Child-proofing the house □Tobacco avoidance

Signature:_____Date:_____
Stamp:

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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