Today's Date:_________

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

9-11 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: ________

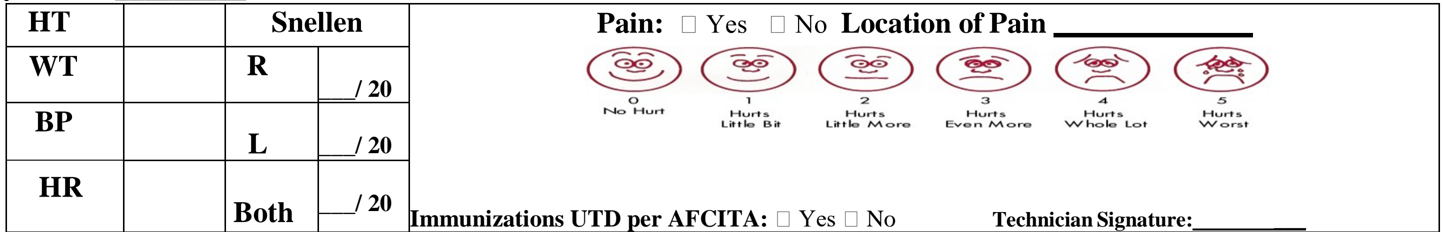
Are there any cultural or religious considerations that may affect your child's healthcare? Yes No _____________

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:

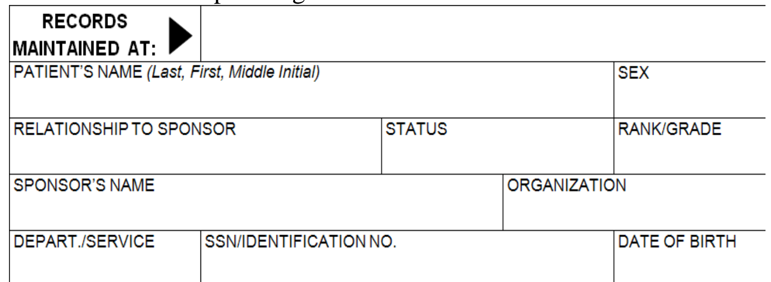
F/U: at next well child visit at___months, sooner if parental concerns

☐ 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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