Today's Date: _____

Patient's name: FMP/Sponsor last 4: Contact Number:
Date of birth:

PEDIATRIC ACUTE/ROUTINE VISIT

What is the reason your child is being seen today?

_____

_____

How long has this been a problem? _____
Is this problem getting better or worse? _____
Does any family member/playmate have similar symptoms?_____

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

Chronic Medical Conditions (Circle all that apply)	**Surgeries/Hospitalizations (Dates)**	**Family History (biological siblings, parents, grandparents) (Circle all that apply)**	**Medicines (PLEASE INCLUDE DOSAGE)**
Hayfever/allergies Asthma ADHD Overweight Chronic ear infections Other:		Hayfever/allergies Asthma Other:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):

Please list any known **ALLERGIES** your child has (drug, food, latex)_____
Would you say your child's **general health** is: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
Does your child attend: ❑ Daycare ❑ Preschool ❑ Public/private school ❑ Home-schooled
Does anyone in the family smoke? ❑ Yes ❑ No

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Cough	Yes/No	Duration?_____
Headache	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Earache	Yes/No	Duration?_____	Abdominal Pain	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Loss	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Sore throat	Yes/No	Duration?_____	Other (Describe)_____		

Pre-teen/teen females only (if applicable): Last menstrual period _____

Preferred language: ❑ English ❑ Other: _____
What is your preferred method for 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
Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure
Do you & your child feel safe at home? ❑ Yes ❑ No
Has your child been seen by a provider outside of the Medical Home Clinic since your last visit? ❑Yes ❑No
If Yes, Where? _____

Today's Date: _____

BP		HT		**Pain:** ❑ Yes ❑ No **Location of Pain**: _____ 
HR		WT		
RR		Sp02		
Temp				**Immunizations UTD per AFCITA:** □Yes □No **Technician Signature:**_____

HPI:

NE	Examination:	Normal	Abnormal
□	General:	□ Active/Alert/WN/WD/NAD	□
□	Head/Neck:	□ NCAT/non-tender/FROM	□
□	Eyes:	□ Clear, no injection, no D/C, PERRL, EOMI	□
□	R ear:	□ TM gray/mobile	□ Bulging/immobile/red
□	L ear:	□ TM gray/mobile	□ Bulging/immobile/red
□	Nose:	□ No congestion/discharge	□ Congested
□	Oropharynx:	□ Pink, moist, no lesions	□
□	Lungs:	□ CTAB, no retractions, nl WOB	□
□	CV:	□ RRR, no murmur, strong pulses, cap refill < 2 sec	□
□	Abd:	□ Soft, NT, no HSM, no masses, nl BS	□
□	Ext:	□ NL, FROM, nontender, no edema	□
□	Skin:	□ No rash	□
□	Lymph:	□ No adenopathy	□
□	Neuro:	□ Nl gait, CN II-XII intact, strength 5/5, sensory intact to touch, DTR 2+/2+	□
□	Psychological:	□ Nl mood and affect	□ Hyperactive behavior □ Impulsive behavior
	Other PE findings:	□	□

ASSESSMENT:

PLAN:

F/U: F/up _____, sooner if parental concerns

☐ Patient and/or parent verbalizes understanding of treatment and plan

PREVENTION: ☐ Safety ☐ Tobacco avoidance ☐ Car Seat/Seatbelt ☐ Safe guard medications

☐ Nutrition ☐ Exercise ☐ Media Time

Signature:_____
Date:
Stamp:
25 Jan 2011 SF 600

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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