

Name \_\_\_\_\_ FMP/SSN last four: \_\_\_\_\_ DOB: \_\_\_\_\_

Email Address : \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

## 6-11 YEAR VISIT

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) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
<b>Hayfever/allergies</b>  <b>Asthma</b>  <b>ADHD</b>  <b>Overweight</b>  <b>Chronic ear infections</b>  <b>Other:</b>	Example Circumcision		<b>Allergies</b>  <b>Asthma</b>  <b>Diabetes</b>  <b>Heart Disease</b>  <b>Obesity</b>	<u>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</u>

**Check if anyone in the family has had:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sudden Death     | <input type="checkbox"/> Heart attack < 50 years      | <input type="checkbox"/> Mental Illness              |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Long QT syndrome | <input type="checkbox"/> Genetic or Metabolic Disease | <input type="checkbox"/> Hypertrophic Cardiomyopathy |

Please list any known **allergies** your child has (drug, food, latex) \_\_\_\_\_

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

Who does your child live with? \_\_\_\_\_

Does your child attend:  Child-care     Public/private school     Home-schooled    (Grade: \_\_\_\_\_)

Does anyone in the family smoke?  Yes  No

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

What is your preferred method for learning:  Verbal     Written     Visual     Other: \_\_\_\_\_

Preferred language:  English     Other: \_\_\_\_\_

Are there cultural or religious considerations that affect your child's healthcare?  Yes  No \_\_\_\_\_

**Please See Reverse Side**

<b>RECORDS MAINTAINED AT:</b>		
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

Ethnic Origin  Filipino  Hispanic  Asian/Pacific Islander  Southeast Asian  Other  Unknown  Decline to Respond

Race  Asian/Pacific Islander  African American  Caucasian  Western Indian  Other  Unknown  Decline to Respond

**Diet/Exercise History:**

Current Diet Less Than 5 Servings a day Of Fruits and/or vegetables  Yes  No

Current Diet High in Fat Content and Includes High Fat Snacks  Yes  No

Current Diet High Fat and includes Frequent Fast Foods  Yes  No

Current Diet High Fat and Includes Fried Foods  Yes  No

Days a Week eating Breakfast \_\_\_\_\_ Days/week Having Dinner with Family \_\_\_\_\_

Eats Extra Large Portions  Yes  No High Sugar Beverages  Yes  No How many ounces per day? \_\_\_\_\_

Caffeinated Beverages  Yes  No How many per week? \_\_\_\_\_

Daily Milk Intake \_\_\_ ounces per day Type of milk?  Whole  2%  1%  Skim

Does your child get at least one hour of physical activity at least 5 times per week?  Yes  No Type of activity: \_\_\_\_\_

How many hours of exposure to TV/video games/computer time does your child have per day? \_\_\_\_\_

Does your child have a TV or internet in their bedroom?  Yes  No

**Check all of the following that apply for your child:**

Appropriate Behavior at Home

Pride in achievements

Appropriate Behavior at School

Talks about activities at school

Appropriate Behavior when playing with friends

Completes school work

Reading and doing math at grade level

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

**Check if your child has had a history of:**

Trauma

Fractures

Fainting during exercise

Head Trauma

Chest pain or discomfort

Exercise intolerance

Concussion

Palpitations

**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 Less 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 \_\_\_\_\_

**FOR STAFF USE ONLY**

		Visual Acuity: R 20/ ____ L 20/ ____ Both 20/ ____
Height		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____ 
BP		
		Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/>

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	<b>General:</b>	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	<b>Head/Neck:</b>	<input type="checkbox"/> NCAT, FROM, Neck supple, NI thyroid, NI lymph nodes	<input type="checkbox"/>
<input type="checkbox"/>	<b>Eyes:</b>	<input type="checkbox"/> PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	<b>R ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>L ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>Nose:</b>	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	<b>Lungs:</b>	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	<b>CV:</b>	<input type="checkbox"/> RRR, no murmur, strong arterial pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	<b>Abd:</b>	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	<b>Ext/Spine:</b>	<input type="checkbox"/> NL, FROM, nontender, no edema, spine straight	<input type="checkbox"/>
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> No rash/skin lesions	<input type="checkbox"/>
<input type="checkbox"/>	<b>Female:</b>	<input type="checkbox"/> NI breasts/Tanner ____ <input type="checkbox"/> NI ext genitalia/Tanner ____	
<input type="checkbox"/>	<b>Male:</b>	<input type="checkbox"/> NI penis, NI scrotum, Testes down, Tanner ____, No hernia	
<input type="checkbox"/>	<b>Neuro:</b>	<input type="checkbox"/> NI tone/strength/DTRs/balance/gait <input type="checkbox"/> CN II-XII intact	<input type="checkbox"/>
<input type="checkbox"/>	<b>Other findings:</b>	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:

ASSESSMENT:  Well child: normal growth & development for age

PLAN:  Fluoride supplementation (as needed locally)  
 Immunizations per clinic schedule

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

PREVENTION:  Dental visits  Safety/Falls  Bike Helmet  Booster Seat  Tobacco avoidance  Sun safety  
 Exercise  Nutrition  Media Time

Signature: \_\_\_\_\_

Date:

Stamp:

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