

6-11 YEAR VISIT

Patient Name:

Sponsor SSN last four:

Patient Date of Birth:

Contact Number: HOME _____ CELL _____

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 (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/allergies Asthma ADHD Overweight Chronic ear infections Other:		Hay fever/Allergies Asthma Other:	<u>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</u> Does your child ever forget to take these medications? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Check if anyone in the family has had:

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

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

Source of Medical Information: Mother Father Patient Other: _____

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

Who does your child live with? _____

Is your child Currently in school Home-schooled Grade: _____

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

Instructions for Patient Understood by Caregiver/Patient? Yes No

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

What is your preferred method for learning: Verbal Written Other: _____

Preferred language: English Other: _____

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

----- Additional Hx/Prevention -----

Check if your child has had a history of:

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Stress | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting during exercise |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Drug Use | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Headache Syndromes |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Seizure Disorder |

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

Do you usually eat dinner as a family? Yes No Does your child usually eat breakfast? Yes No

Does your child eat extra large portions? Yes No Caffeinated beverages? Yes No How many per week? ____

Drink juice? Yes No Ounces per day? ____ Drink milk? Yes No Ounces per day? ____

How much exposure to TV/video games/computer does your child have per day? Less than 2 hours More than 2 hours

Does your child get at least one hour of physical activity per day? Yes No Type of activity: _____

Circle if you have any concerns about the following: Bedwetting / Constipation Amount of Sleep per night: ____ hrs

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

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Check all of the following that apply for your child: (Milestones)

<input type="checkbox"/> Does Chores at Home When Asked	<input type="checkbox"/> Eat Healthy Food and Snacks
<input type="checkbox"/> Get Along Well With Family and Friends	<input type="checkbox"/> Talks about activities at school
<input type="checkbox"/> Engages in After-school Activities	<input type="checkbox"/> 6-11 year milestones: has a positive self-image
<input type="checkbox"/> Reading and Doing Math at Grade Level	

Weight		Visual Acuity: R 20/____ L 20/____ Both 20/____
Height		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  0 No Hurt 1 Hurts Little Bit 2 Hurts Little More 3 Hurts Even More 4 Hurts Whole Lot 5 Hurts Worst Technician Signature: _____
BP		
Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/>		

HPI:

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

Signature: _____ Date: _____

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