

Name		BIRTH DATE	AGE	ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE
			<input type="checkbox"/> M <input type="checkbox"/> F		
ID NUMBER	CURRENT MEDICATIONS See other side for current medication list		DRUG ALLERGIES		
WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	DATE/TIME

See growth chart.

**BF** = Bright Futures Priority Item

**History**

**BF**  Previsit Questionnaire reviewed  Child has special health care needs

**BF** Concerns/questions raised by \_\_\_\_\_  
 None  Addressed (see other side)

**BF** Follow-up on previous concerns  None  Addressed (see other side)

**BF**  Medication Record reviewed and updated

**Social/Family History**

**BF** Family situation  Single Parent

**BF** Parental support-work/family balance \_\_\_\_\_

Maternal Depression  Yes  No \_\_\_\_\_

PHQ 9  Pass  Refer  
 PHQ 2  Pass  Refer  
 Edinburgh  Pass  Refer

**BF** Parents working outside home:  Mother  Father

**BF** Child care:  Yes  No Type \_\_\_\_\_

**BF** Changes since last visit \_\_\_\_\_

**BF**  Tobacco Exposure

**Review of Systems**

= NL

Date of last visit \_\_\_\_\_

Changes since last visit \_\_\_\_\_

**Nutrition:**  Breast milk Minutes per feeding \_\_\_\_\_  
 Hours between feeding \_\_\_\_\_ Feedings per 24 hours \_\_\_\_\_  
 Problems with breastfeeding \_\_\_\_\_  
 Formula Ounces per feeding \_\_\_\_\_  
 Solid foods \_\_\_\_\_  
 Source of water \_\_\_\_\_ Vitamins/Fluoride \_\_\_\_\_

**Elimination:**  NL \_\_\_\_\_

**Sleep:**  NL \_\_\_\_\_

**Behavior:**  NL \_\_\_\_\_

**Development** (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> PHYSICAL DEVELOPMENT *Pushes chest up to elbows *Good head control *Symmetry in movements *Begins to roll and reach for objects	<input type="checkbox"/> COMMUNICATIVE *Spontaneous expressive babbling <input type="checkbox"/> COGNITIVE *Responds to affection *Indicates pleasure and displeasure <input type="checkbox"/> SOCIAL-EMOTIONAL *Social smile *Elicits social interactions *Can calm down on own
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BRIGHT FUTURES

(see other side for plan, immunizations and follow-up)

**Physical Examination**

= Reviewed w/Findings **OR**  NL = Reviewed/Normal

GENERAL APPEARANCE \_\_\_\_\_  NL

**BF**  SKIN (rashes, bruising) \_\_\_\_\_  NL

**BF**  HEAD / FONTANELLE (positional skull deformities) \_\_\_\_\_  NL

**BF**  EYES (red reflex/strabismus/appears to see) \_\_\_\_\_  NL

EARS/APPEARS TO HEAR \_\_\_\_\_  NL

NOSE \_\_\_\_\_  NL

MOUTH AND THROAT \_\_\_\_\_  NL

NECK \_\_\_\_\_  NL

LUNGS \_\_\_\_\_  NL

**BF**  HEART \_\_\_\_\_  NL

**BF**  FEMORAL PULSES \_\_\_\_\_  NL

ABDOMEN \_\_\_\_\_  NL

HERNIA \_\_\_\_\_  NL

GENITALIA \_\_\_\_\_  NL

Male/Testes down \_\_\_\_\_  NL

Female \_\_\_\_\_  NL

**BF**  NEUROLOGIC / GAIT (tone, strength, symmetry) \_\_\_\_\_  NL

EXTREMITIES \_\_\_\_\_  NL

**BF**  MUSCULOSKELETAL (torticollis) \_\_\_\_\_  NL

**BF**  HIPS \_\_\_\_\_  NL

NO DYSMORPHISMS \_\_\_\_\_  NL

HYGIENE \_\_\_\_\_  NL

BACK \_\_\_\_\_  NL

**BF** Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Assessment**

**BF**  Well Child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Anticipatory Guidance**

= Discussed and/or handout given

Identified at least one child and parent strength

Raising Readers book given

Describe immunization side effects & when to call

<input type="checkbox"/> FAMILY FUNCTIONING	<input type="checkbox"/> INFANT DEVELOPMENT	<input type="checkbox"/> SAFETY
<input type="checkbox"/> NUTRITIONAL ADEQUACY AND GROWTH	• Social development	• Car safety seat (infant rear facing)
• Breastfeeding (vitamin D, iron supplement)	• Communication skills	• Burns
• Iron-fortified formula	• Physical (tummy time)	• Hot liquids
• Solid foods	• Daily routines	• Water heater
• When and how to add	• Sleep	• Walkers
• Weight gain and growth spurts	<input type="checkbox"/> ORAL HEALTH	• Drowning
• Elimination	• Don't share utensils/pacifier	• Choking
	• Avoid bottle in bed	• Lead Poisoning
		• Sun Safety

BRIGHT FUTURES

