Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

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? _____

Have you been seen for this before?_____ Any treatment you have tried?_____

Does any family member/playmate have similar symptoms?_____

Any recent ER visits? ❑Yes ❑ No **When: _____ Reason:_____**

********(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)**
Hay fever/Allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**		**Hay fever/Allergies** **Asthma** **Sudden death** **Heart attack <50** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Does your child ever forget to take their medications? ❑ Yes ❑ No

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 either of the child's parents on **PRP status?** ❑Yes ❑ No

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

Who does your child live with? _____

Does your child attend: ❑ DOD school ❑ British school ❑ Home-school Grade? ____ ❑ Aftercare **Any Concerns?** ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Would you say your child's overall health is: Excellent / Very Good / Good / Fair / Poor

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 _____

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)_____		
Changes in urine output	Yes/No		Changes in stooling habits	Yes/No	

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

Wt		HR		Pain: ❑ Yes ❑ No Location of Pain _____
Ht		RR		
BMI/%		SpO2		
Temp		BP		Imm UTD per ASIMS: ❑ 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	□
□	**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 s 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+	□
□	**Other findings:**	□	□

LABS/X-RAYS:

ASSESSMENT:

PLAN:

F/U:

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

PREVENTION: □ Hand washing □ Safety □ Tobacco avoidance □ Car Seat/Seatbelt
□ Exercise □ Nutrition □ Media Time

Signature:_____
Date:
Stamp:

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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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