

THIS SECTION TO BE COMPLETED BY PARENT

Review of Systems

- Are you concerned about your child's... (circle concerns)
- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. eating habits, weight loss, ↓ energy, sleep habits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. redness, excessive tearing or discharge from eyes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. recurrent ear, sinus or throat infections; nosebleeds..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. chest pain, shortness of breath, or irregular heart beat..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. frequent colds, cough, wheezing, recurrent bronchitis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. abdominal pain, vomiting, diarrhea, constipation..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. urinary control, bed wetting, urinary infections..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. joint pain, stiffness, swelling; muscle pain, weakness..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. birthmarks, skin rashes, itching, nail or hair problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. recurrent headaches, dizziness, tics, weakness, seizures..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. mood changes, sadness, nervous problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. excessive thirst or hunger, ↑ urination, weight loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. paleness, anemia, easy bruising, swollen glands..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. milk, food or drug allergies, recurrent infections..... | <input type="checkbox"/> | <input type="checkbox"/> |

Personal/Social History

- Do you have any concerns about your child's...
- | | YES | NO |
|--|--------------------------|--------------------------|
| a. overall progress in school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. happiness at school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. ability to sit still, listen or participate in school activities..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. willingness to follow the rules at school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. ability to get along with classmates and teachers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. attendance at school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. overall physical well being..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. poor eating habits, excessive or improper snacks..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. poor sleeping habits, nightmares, sleep walking or talking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. lack of energy or stamina..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. irritability, temper outbursts, excessive anger..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. lack of personal hygiene, hand washing, brushing teeth, e.t.c..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Do you have any other concerns about development or behavior?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Do you participate in the activities at school?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Are you able to spend individual time with your child daily?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Does your child have adult supervision before and after school?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Does your child participate in any sports after school?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Does your child have assigned chores to do?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| s. Does your child use a helmet for skating or biking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Does your child use a safety belt and ride in the back seat?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| u. Does anyone have a gun in the home?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Lead Screen

- Does your child...
- Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative).....
 - Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?.....
 - Have a sibling or playmate who now has or did have lead poisoning?.....
- Do you have any concerns you wish to discuss?.....

Parent's Signature

Date

Parent's section reviewed by

History

Previous concerns, consults and procedures reviewed

(Interval: No Change) Concerns

Current Medications

Drug Allergies Yes No

Past / Social / Family History (Interval: No Change)

Provider Comments

Anticipatory Guidance

General

- Growth /Dev.
- School
- Exercise
- Limit television
- Dental care
- Passive smoke
- Ed. Handouts

Nutrition

- Low fat dairy foods
- Nutritious diet
- Proper snacks
- Variable appetite
- Pleasant mealtimes
- Fluoride /F1 water

Injury Prevention

- Seat belt
- Burns
- Bicycle helmets
- Playground safety
- Parent supervision
- Swimming pools
- Sun exposure
- Gun safety