SOUTHLAKE PEDIATRICS
HEALTH SUPERVISION VISIT 6-7 YEARS

Name: ______________________ DOB: __________

Date of Visit ______________________ Age __________

Parental Language Barrier: ☐ N ☐ Y __________________

PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

☐ No Concerns

____

____

____

PAST MEDICAL HISTORY

Allergies ______________ Immunization Reactions __________

Other ______________________________________

____

PRESENT HISTORY

Meds: ______________________________________

Diet

Calcium ______________________________

Fruit/Veg ______________________________

Exercise ______________________________________

Bowel movements ______________________________

Sleep ______________________________________

Dental ______________________________________

SCHOOL

Grade ______________________________________

Performance ______________________________________

After School care ______________________________

SOCIAL

Activities ______________________________________

Friends ______________________________________

Behavior/Discipline ______________________________

Daily screen time ______________________________

FAMILY

Smoke Exposure ☐ Yes ☐ No ______________________

Other ______________________________________

____

____

____

Information completed by: ______________________

Relationship to child: ______________________

PHYSICAL EXAMINATION

Length ________ Weight ________ BMI ________ BMI% ________

BP ________ Temp ________

N	AB		COMMENTS
☐	☐	Gen. Appearance	
☐	☐	Skin	
☐	☐	Head	
☐	☐	Eyes/RR/Strabismus	
☐	☐	Ears/Nose/Oropharynx	
☐	☐	Neck/Nodes	
☐	☐	Chest/Lungs	
☐	☐	Cardiovascular/Pulses	
☐	☐	Abdomen	
☐	☐	Genitalia	
☐	☐	Musculoskeletal	
☐	☐	Neuro/Reflexes	
☐	☐	Hearing (formal)	R ________ L ________
☐	☐	Vision (formal)	R ________ L ________

ANTICIPATORY GUIDANCE

Diet
- ☐ Family Meals
- ☐ Healthy Choices

Injury Prevention
- ☐ Booster seat/Seatbelts
- ☐ Sports/Bicycle Safety/Helmets
- ☐ Water/Swimming Safety
- ☐ Fire Safety

Development
- ☐ Family Time
- ☐ Communication/Feelings
- ☐ Teach Conflict Resolution
- ☐ Praise/Affection
- ☐ TV Habits
- ☐ Outside activities

Healthy Habits
- ☐ Exercise
- ☐ Family Role Models

Medical Education
- ☐ Review Immunizations
- ☐ Telephone

LABS: ☐ U/A ____________ ☐ Hgb/Hct ____________

ASSESSMENT/RECOMMENDATIONS:

☐ Healthy Child ☐ Dental Referral ______________________

☐ Review Immunizations

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____

☐ Return for ☐ 8 - ☐ 9 year checkup

______________________, M.D.

SICK VISIT – Mod 25

CC:

HPI:

MDM:

>50% of ________ min visit spent counseling