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 _____

Elimination _____

Sleep _____

Dental _____

SCHOOL

Grade _____

Performance _____

After School care _____

SOCIAL

Activities _____

Friends _____

Behavior/Discipline _____

TV _____

FAMILY

Smoke Exposure ☐ Yes ☐ No _____

Other _____

_____

_____

_____

Information completed by: _____

Relationship to child: _____

PHYSICAL EXAMINATION

Length _____ Weight _____ BMI _____ BMI% _____

BP _____ Temp _____ Pain _____

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

_____

_____

_____

☐ Return for ☐ 8 - ☐ 9 year checkup

_____, M.D.

SICK VISIT – Mod 25

CC:

HPI:

MDM:

>50% of _____min visit spent counseling