Problem Visit

Accompanied By:	Preferred Language:	Date/Time:	**Name:**

Drug Allergies:	Current Medications (See Medication Record.): ☐ Reviewed and updated	ID Number:

Weight (%):	Height (%):	BMI (%):	Birth Date:	Age:	Sex: M F

Temp (route):	Resp Rate:	HR:	BP:	SpO_2:

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

Location, timing, quality, severity, context, and modifying factors:

REVIEW OF SYSTEMS

☑ = System reviewed and negative   Circle positive symptoms and write additional symptoms on line provided.

System	Negative	Positive For
Constitutional	☐	Fevers, chills, or fatigue ______
Eyes	☐	Conjunctivitis or drainage ______
Head, Ears, Nose, and Throat	☐	Congestion, rhinorrhea, ear pain _____, or pharyngitis ______
Lymphatic	☐	Adenopathy or tenderness ______
Cardiovascular	☐	Tachycardia or palpitations ______
Respiratory	☐	Cough, wheeze, or shortness of breath ______
Gastrointestinal	☐	Abdominal pain, vomiting, or diarrhea ______
Genitourinary	☐	Dysuria, frequency, or urgency ______
Musculoskeletal	☐	Myalgias, arthralgias, or back pain ______
Skin	☐	Rashes or bruising ______
Neurological	☐	Headaches or light-headedness ______
Psychiatric	☐	Depression, anxiety, or mood lability ______

Additional comments:

SAMPLE
For Review and Reference Only

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

The recommendations in this form do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original form included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this form and in no event shall the AAP be liable for any such changes.

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Problem Visit

Name: ______________________________

HISTORY

Areas reviewed:

Problem List (See Problem List.)	☐ No interval change	☐ Updated
Past Medical History (See Initial History Questionnaire.)	☐ No interval change	☐ Updated
Social and Family History (See Initial History Questionnaire.)	☐ No interval change	☐ Updated
Immunizations (See Vaccine Administration Record.)	☐ Up-to-date for age: ______________________	

PHYSICAL EXAMINATION

☑ = System examined. Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

☐ **General:** Well appearing, in no acute distress. ______________________

☐ **Eyes:** Pupils equal, round, and reactive to light. Extraocular eye movements intact. ______________________

☐ **Head, ears, nose, and throat:** Tympanic membranes normal bilaterally. No oral lesions. ______________________

☐ **Neck:** Supple, with no significant cervical adenopathy. ______________________

☐ **Heart:** Regular rate and rhythm. No murmur. ______________________

☐ **Respiratory:** Breath sounds clear bilaterally. Comfortable work of breathing. ______________________

☐ **Abdomen:** Soft and non-tender. ______________________

☐ **Genitourinary:** Normal external genitalia. No lesions. ______________________

☐ **Musculoskeletal:** Full range of motion. No joint swelling. ______________________

☐ **Neurological:** Cranial nerves II to XII grossly intact. Moves all extremities equally. ______________________

☐ **Skin:** Warm and well perfused. No rashes. ______________________

☐ **Psychiatric:** Full affect. Makes appropriate eye contact. ______________________

Additional comments:

SAMPLE
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ASSESSMENT AND PLAN

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition