



6 Year Visit (Also Appropriate for 7 Year Visit) ID#

Date:

Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____

Bright Futures



Wt.	(___ %)	Ht.	(___ %)	BMI	T	P	R	BP
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QUESTIONS FOR PARENT

- Does _____ talk to you about what's happening in school?
- What does _____ eat for an after-school snack?
- How many hours a day does _____ sleep? Does he seem rested when he wakes up?

QUESTIONS FOR CHILD

- ★ How is school going? What do you like the most about school? The least?
- ★ Draw me a picture of your family. Tell me a story about them.

SCHOOL PERFORMANCE

- When _____ plays with other children, can he keep up with them?
- How do you acknowledge and praise _____'s achievements at school?
- Have you visited _____'s classroom?

FAMILY'S QUESTIONS

- What questions or concerns would you like to discuss today?

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>
Head	<input type="checkbox"/>	Back	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Extremities	<input type="checkbox"/>
Nose/throat	<input type="checkbox"/>	Feet	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Lungs	<input type="checkbox"/>		

If abnormal, explain:



Name: _____



ANTICIPATORY GUIDANCE

Healthy habits

- ☐ Adequate sleep, physical activity
☐ Limit TV
☐ Personal hygiene
☐ Seat belt, bike helmet
☐ Safety: pedestrian, playground, stranger
☐ Sunscreen
☐ Matches, poisons, guns
☐ Safe after-school environment
☐ Rules for behavior
☐ Family meals
☐ Food choices (fruits, veg., grains)
☐ Brush teeth
☐ Fluoride, dental sealants
☐ See dentist
☐ Dental emergency care
☐ Sucking habits
☐ Questions about sex
☐ Sex education at home

Social competence

- ☐ Praise, encourage expression
☐ Reading
☐ Individual attention
☐ Family activities
☐ Limits, consequences
☐ Self-discipline
☐ Family rules, respect, right from wrong
☐ Handle anger, conflict resolution
☐ Foster communication with adults
☐ Chores
☐ Personal space

Family relationships

- ☐ Listen, respect, interest in activities
☐ Affection
☐ Play with child
☐ Sibling relationships
☐ Know child's friends/families
☐ Reasonable expectations
☐ Ethical role model

Community interaction

- ☐ Referrals
☐ Community and school programs
☐ After-school care
☐ Health education in schools

SCREENING

- Vision R _____ L _____
Hearing R _____ L _____
Assess lead risk _____
Assess hyperlipidemia risk _____
If risk:
PPD _____

IMMUNIZATIONS

- Immunizations up to date? _____
Side effects discussed?
Diphtheria, tetanus, pertussis # _____ ☐
Polio # _____ ☐
Measles, mumps, rubella # _____ ☐

SUMMARY

- Summarize visit
Arrange continuing care _____

REFERRAL

Phone Numbers

- Health Insurance _____ ☐
SSI _____ ☐
WIC _____ ☐
Food Stamps _____ ☐
Social Services _____ ☐
Housing _____ ☐
Other: _____

NOTES:



Signature: _____



Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____

Bright Futures



Wt. (___ %)	Ht. (___ %)	BMI	T	P	R	BP
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QUESTIONS FOR PARENT

- Does ____ bring friends home? Does she go to friends' homes?
- What does ____ do when she is stressed, angry, or frustrated?
- What are the rules at home regarding food, movies, toys, language, and makeup?
- What language does your family speak at home?

QUESTIONS FOR CHILD

- ★ How is school going?
- ★ What are you the best at? What are you really proud of?
- ★ Tell me about your friends.
- ★ Do you stay home by yourself, either before or after school?

SCHOOL PERFORMANCE

- Do you have any specific concerns about ____'s school work or behavior?
- Is ____ reading and doing math at grade level? Is she in any special classes?
- What did the teacher say about ____ during your parent-teacher conference?

FAMILY'S QUESTIONS

- What questions or concerns would you like to discuss today?

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Back (scoliosis)	<input type="checkbox"/>
Head	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Extremities	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Feet	<input type="checkbox"/>
Nose/throat	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Females	
Lungs	<input type="checkbox"/>	Early puberty	<input type="checkbox"/>
Heart	<input type="checkbox"/>		

If abnormal, explain:



Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____

Bright Futures



Wt.	Ht.	BMI	T	P	R	BP
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QUESTIONS FOR PARENT

- How is _____ doing in school?
- How much television does _____ watch?
- What are some of your family's traditions?
- Have you discussed menstruation or wet dreams?

QUESTIONS FOR CHILD

- ★ Do your friends pressure you to do things you don't want to?
- ★ Do you get any of your own meals? What do you like to eat?
- ★ What education have you had about sex?

SCHOOL PERFORMANCE

- Is _____ reading and doing math at grade level?
- Do you participate in activities at _____'s school?
- Has _____ identified certain interests or talents he would like to pursue?

FAMILY'S QUESTIONS

- What questions or concerns would you like to discuss today?
- _____
- _____

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Back (scoliosis)	<input type="checkbox"/>
Head	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Extremities	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Feet	<input type="checkbox"/>
Nose/throat	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Females	
Lungs	<input type="checkbox"/>	Early puberty	<input type="checkbox"/>
Heart	<input type="checkbox"/>		

If abnormal, explain:



Name: _____



ANTICIPATORY GUIDANCE

Healthy habits

- ☐ Adequate sleep, physical activity
☐ Personal hygiene
☐ TV, music
☐ Tobacco, alcohol, drugs
☐ Some supervision
☐ Reinforce safety lessons and rules
☐ Guns
☐ Family meals
☐ Healthy food choices
☐ Brush teeth
☐ Fluoride
☐ See dentist
☐ Dental sealants
☐ Puberty, sexual development
☐ Answer questions about sex
☐ Abstinence

Social competence

- ☐ Praise, encourage expression
☐ Reading, hobbies
☐ Individual attention
☐ Group, team activities
☐ Talents
☐ Limits, consequences
☐ Family rules
☐ Handle anger, conflict resolution
☐ Adult interactions
☐ Chores
☐ Personal space

Family relationships

- ☐ Ethical role model
☐ Listen, respect, interest in activities
☐ Family activities
☐ Affection
☐ Reasonable expectations
☐ Sibling relationships
☐ Child's friends and their families

Community interaction

- ☐ Referrals
☐ Child care
☐ School, cultural, community involvement
☐ Health education in schools

SCREENING

Vision R _____ L _____
Hearing R _____ L _____
Assess hyperlipidemia risk _____

If risk:

PPD _____

SUMMARY

Summarize visit
Arrange continuing care _____

REFERRAL

Phone Numbers

- Health Insurance _____ ☐
SSI _____ ☐
WIC _____ ☐
Food Stamps _____ ☐
Social Services _____ ☐
Housing _____ ☐
Other: _____

NOTES:



Signature: _____



Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____

Bright Futures



Wt.	Ht.	BMI	T	P	R	BP
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QUESTIONS FOR PARENT

- How is _____ doing in school? What does he do after school?
- What has _____ been taught in school or at home about drugs, sex, and other health topics?
- Have you clearly stated rules about how you want _____ to act?

QUESTIONS FOR ADOLESCENT

- ★ Who is your best friend? What do you and your friends do for fun?
- ★ Tell me some of the things you're really good at.
- ★ Do your friends try to pressure you to do things that you don't want to do? How do you handle that?
- ★ How much time each week do you spend watching television or playing video games?
- ★ Has anyone talked with you about what to expect as your body develops?
- ★ Have you started dating? Do you have any worries or questions about sex?
- ★ Who do you live with? How do you get along with your family?

SCHOOL PERFORMANCE

- ★ How are you doing in school? How often do you miss school?
- ★ What activities or sports are you involved in?

FAMILY'S QUESTIONS

- What questions or concerns would you like to discuss today?

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Skin (acne)	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Head	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Tanner stage	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Females	
Nose/throat	<input type="checkbox"/>	Condyloma/lesions	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	Instruction in breast	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	self-exam	
Neck	<input type="checkbox"/>	Males	
Lungs	<input type="checkbox"/>	Gynecomastia	<input type="checkbox"/>
Heart	<input type="checkbox"/>	Hernias, condyloma/	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	lesions	
Back (scoliosis)	<input type="checkbox"/>	Testicular cancer	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	Instruction in testicular	<input type="checkbox"/>
Feet	<input type="checkbox"/>	self-exam	

If abnormal, explain:



Name: _____



ANTICIPATORY GUIDANCE

Healthy habits

- ☐ Adequate sleep, exercise
☐ Athletic conditioning, fluids
☐ Weight training, changes
☐ Limit TV
☐ Seat belts, helmets, sunscreen
☐ Protective sports gear
☐ Smoke-free environment
☐ Home-alone rules
☐ Weapons
☐ Learn to swim
☐ Challenges, self-confidence
☐ Listen to friends/adults
☐ Stress, nervousness, sadness
☐ Three meals a day, nutritious snacks
☐ Family meals
☐ Food choices (fruits, vegs, grains)
☐ Iron, calcium
☐ Sugar, high-fat foods
☐ Weight management
☐ Brush teeth
☐ Fluoride, dental sealants
☐ Dental emergency care
☐ See dentist
☐ Body changes
☐ Sexual feelings normal
☐ How to say no, abstinence
☐ Birth control, safer sex
☐ Cigarettes, spit tobacco
☐ Diet pills, steroids
☐ Alcohol, drugs
☐ Peer counseling

Social competence

- ☐ Family time
☐ Respect parents' limits/consequences
☐ Social activities, groups, sports
☐ Peers, sibling relationships
☐ Peer pressure, peer refusal

Responsibility

- ☐ Respect others
☐ Ethical role model
☐ Rules, chores, responsibilities
☐ New skills, talents, interests

School achievement

- ☐ School transitions
☐ Attendance, homework
☐ Frustrations, dropping out
☐ School activities
☐ Future plans, college, career

Community interaction

- ☐ Religious, cultural, volunteer activities
☐ Social responsibility
☐ Referrals

SCREENING

PPD (once at 14-16) _____

If risk:

Vision R _____ L _____

Hearing R _____ L _____

PPD _____

Hematocrit or hemoglobin (females) _____

Hyperlipidemia _____

If sexually active:

Annual pelvic exam (females) _____

Gonorrhea, chlamydia _____

Syphilis, HIV _____

Urine dipstick for leukocytes _____

IMMUNIZATIONS

Immunizations up to date? _____

Side effects discussed?

Hepatitis B # _____ ☐

Tetanus and diphtheria toxoids _____ ☐

Measles, mumps, rubella # _____ ☐

Varicella # _____ ☐

SUMMARY

Summarize visit

Arrange continuing care _____

REFERRAL

Phone Numbers

Health Insurance _____ ☐

SSI _____ ☐

WIC _____ ☐

Food Stamps _____ ☐

Social Services _____ ☐

Housing _____ ☐

Other: _____

NOTES:

Signature: _____



Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____



Wt.	Ht.	BMI	T	P	R	BP
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QUESTIONS FOR ADOLESCENT

- ★ What do you do for fun? Is it easy or hard for you to make friends?
- ★ Do you ever feel really down and depressed? Who do you talk to about these feelings?
- ★ How do you feel about the way you look? About your weight? What kind of exercise do you get?
- ★ Do you work? How many hours per week?
- ★ Do you smoke cigarettes, drink alcohol, or use drugs? How often?
- ★ Do you date? Do you have a steady partner? Are you happy?
- ★ Have you begun having sex? Do you use birth control? What kind?
- ★ Are the rules in your family clear and reasonable?

SCHOOL PERFORMANCE

- ★ Is school work difficult for you? How often do you miss school?
- ★ What activities or sports are you involved in?

QUESTIONS FOR PARENT (IF PRESENT)

- What about _____ makes you proud?
- Do you feel _____ 's school work matches her future goals or your goals for her?
- Have you talked with _____ about sexuality and your values about sex?
- What are some of your family's traditions?

FAMILY'S QUESTIONS

- ★ What questions or concerns would you like to discuss today?
- _____
- _____

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>
Skin (acne)	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Head	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Tanner stage	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Females	
Nose/throat	<input type="checkbox"/>	Condyloma/lesions	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	Instruction in breast	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	self-exam	
Neck	<input type="checkbox"/>	Males	
Lungs	<input type="checkbox"/>	Gynecomastia	<input type="checkbox"/>
Heart	<input type="checkbox"/>	Hernias, condyloma/	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	lesions	
Back (scoliosis)	<input type="checkbox"/>	Testicular cancer	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	Instruction in testicular	<input type="checkbox"/>
Feet	<input type="checkbox"/>	self-exam	

If abnormal, explain:



Name: _____



ANTICIPATORY GUIDANCE

Healthy habits

- Checklist of healthy habits including sleep, exercise, diet, safety, and social skills.

Social competence

- Checklist of social competence items like family time, social activities, and peer pressure.

Responsibilities

- Checklist of responsibilities including respecting others, rules, and new skills.

School achievement

- Checklist of school achievement items like attendance, frustrations, and future plans.

Community interaction

- Checklist of community interaction items like referrals, religious activities, and social responsibility.

SCREENING

PPD (once at 14-16) _____
Assess hyperlipidemia risk _____

If risk:

Vision R _____ L _____

Hearing R _____ L _____

PPD _____

Hematocrit or hemoglobin (females) _____

Hyperlipidemia _____

If sexually active:

Annual pelvic exam (females) _____

Gonorrhea, chlamydia _____

Syphilis, HIV _____

Urine dipstick for leukocytes _____

IMMUNIZATIONS

Immunizations up to date? _____

Side effects discussed?

Tetanus and diphtheria toxoids _____

SUMMARY

Summarize visit

Arrange continuing care _____

REFERRAL

Phone Numbers

Health Insurance _____

SSI _____

WIC _____

Food Stamps _____

Social Services _____

Housing _____

Other: _____

NOTES:



Name: _____

DOB: _____ Sex: _____

Parent Name: _____ Phone: _____

Bright Futures



Wt.	Ht.	BMI	T	P	R	BP
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QUESTIONS FOR ADOLESCENT

- ★ What do you do for fun? Is it easy or hard for you to make friends?
- ★ Do you feel you'll be successful and achieve what you would like to do?
- ★ How do you feel about the way you look? About your weight? Do you exercise?
- ★ Are you going to school? Are you working? How many hours a week? How are things going at school/work?
- ★ Do you smoke cigarettes, chew tobacco, drink alcohol, or take drugs? How often?
- ★ Do you own a gun? Have you ever witnessed violence? Has anyone ever tried to harm you?
- ★ Have you begun having sexual intercourse? Do you use a kind of birth control? Condoms? Have you ever been pregnant?
- ★ How are you and your parents dealing with you living away from home or preparing to do so?

QUESTIONS FOR PARENT (IF PRESENT)

- Have you made any plans for _____'s health insurance coverage when she is at school/living on her own?

FAMILY'S QUESTIONS

- ★ What questions or concerns would you like to discuss today?

INTERVAL HISTORY

Medications: _____

Allergies: _____

Recent injury/illness: _____

Special health care needs: _____

Visits to other health care providers, facilities: _____

Changes/stressors in family or home: _____

PHYSICAL EXAM

	Normal		
General	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>
Skin (acne)	<input type="checkbox"/>	Signs of abuse	<input type="checkbox"/>
Head	<input type="checkbox"/>	Tanner stage	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Females	
Ears	<input type="checkbox"/>	Condyloma/lesions	<input type="checkbox"/>
Nose/throat	<input type="checkbox"/>	Instruction in	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	breast self-exam	
Teeth	<input type="checkbox"/>	Males	
Neck	<input type="checkbox"/>	Gynecomastia	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	Hernias,	<input type="checkbox"/>
Heart	<input type="checkbox"/>	condyloma/lesions	
Abdomen	<input type="checkbox"/>	Testicular cancer	<input type="checkbox"/>
Back (scoliosis)	<input type="checkbox"/>	Instruction in testicular	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	self-exam	
Feet	<input type="checkbox"/>		
Neurologic	<input type="checkbox"/>		

If abnormal, explain:



Name: _____



ANTICIPATORY GUIDANCE

Healthy habits

- ☐ Adequate sleep, exercise
☐ Athletic conditioning, fluids
☐ Weight training, changes
☐ Diet pills, steroids
☐ Seat belts, speed limits
☐ Protective helmets, mouthguards, gear
☐ Sunscreen, tanning salons
☐ Job safety
☐ Cigarettes, spit tobacco
☐ Alcohol, drugs, weapons
☐ Self-protection
☐ Handle anger, conflict resolution
☐ Self-confidence, strengths
☐ Trust feelings, listen to friends/adults
☐ Stress, depression, hopelessness
☐ Goals (challenging, reasonable)
☐ Spirituality
☐ Three meals a day, nutritious snacks
☐ Sugar, high-fat foods
☐ Food choices (fruits, veg., grains)
☐ Weight management
☐ Brush teeth
☐ Dental emergency care
☐ See dentist
☐ Readiness for sex
☐ Birth control, STDs, safer sex, abstinence
☐ Limit sex partners, use condoms correctly
☐ Gay/lesbian issues
☐ Peer counseling

Social competence

- ☐ Social activities, groups, sports
☐ Family, sibling, peer relationships
☐ Peer pressure, peer refusal

Responsibilities

- ☐ Respect others
☐ Ethical role model
☐ Chores
☐ New skills
☐ Health care consumer

School achievement

- ☐ Talents
☐ Future plans, college, career

Community interaction

- ☐ Referrals
☐ Religious, cultural, volunteer activities
☐ Community advocacy
☐ Social responsibility

SCREENING

Assess hyperlipidemia risk _____

If risk:

Vision R _____ L _____

Hearing R _____ L _____

PPD _____

Hematocrit or hemoglobin (females) _____

Hyperlipidemia _____

If sexually active:

Annual pelvic exam (females) _____

Gonorrhea, chlamydia _____

Syphilis, HIV _____

Urine dipstick for leukocytes _____

SUMMARY

Summarize visit

Arrange continuing care _____

REFERRAL

Phone Numbers

Health Insurance _____ ☐

SSI _____ ☐

WIC _____ ☐

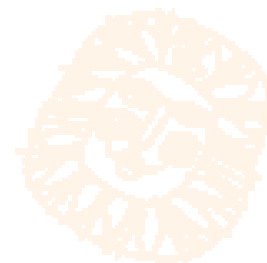
Food Stamps _____ ☐

Social Services _____ ☐

Housing _____ ☐

Other:

NOTES:



Signature: _____