

PREVENTIVE HEALTH PEDIATRIC TRACKING FORM*— AGES BIRTH TO 10 YEARS

Patient's Name _____ Gender: Sex: M / F

Patient's Number _____ Date of First Visit _____ Date of Birth _____

ALLERGIES/ADVERSE REACTIONS

DATE:			
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EXAMINATION/SCREENING

History and Physical				
Temperature/Respiratory Rate				
Pulse/Blood Pressure (Goal _____)				
Height				
Weight/BMI (Goal _____)				
Assessment for Abuse/Neglect/Depression/Eating Disorder				
Environmental Risk Assessment				
Scoliosis Screening				
Diabetes (Every 2 years starting at age 10 if at risk)▼				
Hearing/Vision per AAP Recommendations				
Developmental Behavioral Assessment				

 Refer to the ACIP Recommended Immunization Schedule at <http://www.cdc.gov/nip>

HEALTH EDUCATION/DISCUSSION TOPICS

Proper Nutrition/Physical Activity/Weight Management				
CPR Training for Parents/Caregivers				
Safety Concerns (e.g., car/water/bike)				
Secondhand Smoke Exposure/Environmental Risk Factors				
Discuss Depression/Suicide Risk				
Safe Storage Drugs/Toxic Substances/Firearms/Matches				
Home Fire Safety Drills/Smoke Detectors/CO Monitor				
Poison Control #/Proper use of 911				
Proper Dental Care/Fluoride Supplements▼				
Infant Sleep Environment and Sleep Position				
Hot Water Heater Temp/Bath < 120°F				
Maternal Child Bonding (as appropriate)				

LAB

HgB and HCT				
Tuberculosis Testing▼				
Urinalysis				
Lead Screening				
Practitioner Initials				

 *Refer to Plan-adopted Preventive Health Guidelines for reference listings at www.ibx.com

▼Assess for individual screening risk and frequency needs.

 A = Assessed
R = Refused

 P = Poor
N = Normal Result

 F = Fair
AB = Abnormal Result

 G = Good
E = Done Elsewhere

C = Counseled

PREVENTIVE HEALTH ADOLESCENT TRACKING FORM*— AGES 11 TO 18 YEARS

Patient's Name _____ Gender: Sex: M / F

Patient's Number _____ Date of First Visit _____ Date of Birth _____

ALLERGIES/ADVERSE REACTIONS

DATE:				
EXAMINATION/SCREENING				
History and Physical				
Temperature				
Pulse/Blood Pressure (Goal _____)				
Height				
Weight/BMI (Goal _____)				
Assessment for Abuse/Neglect/Depression/Eating Disorder				
Environmental Risk Assessment				
Scoliosis Screening				
Diabetes (Every 2 years starting at age 10 if at risk)▼				
STDs▼ (e.g., chlamydia, gonorrhea) as appropriate				
Drug/Alcohol Use				
Hearing/Vision per AAP Recommendations				
Refer to the ACIP Recommended Immunization Schedule at http://www.cdc.gov/nip				
FEMALES ONLY				
Pap (after first coitus)▼				
Pelvic Exam (as appropriate)				
HEALTH EDUCATION/DISCUSSION TOPICS				
Proper Nutrition/Physical Activity/Weight Management				
CPR Training for Parents/Caregivers				
Safety Concerns (e.g., car/bike/water)				
Secondhand Smoke Exposure/Tobacco Use/Environmental Risk Factors				
Discuss Depression/Suicide Risk				
Safe Storage Drugs/Toxic Substances/Firearms/Matches				
Home Fire Safety Drills/Smoke Detectors/CO Monitor				
Poison Control #/Proper use of 911				
Proper Dental Care/Fluoride Supplements▼				
Violence/Abuse Counseling				
Sex Education/Use of Contraceptives▼				
LAB				
Tuberculosis Testing▼				
Urinalysis				
Practitioner Initials				

 *Refer to Plan-adopted Preventive Health Guidelines for reference listings at www.ibx.com

▼Assess for individual screening risk and frequency needs.

A = Assessed

P = Poor

F = Fair

G = Good

C = Counseled

R = Refused

N = Normal Result

AB = Abnormal Result

E = Done Elsewhere