

**SUNRISE PEDIATRICS**

3061 S Maryland Pkwy #101

Las Vegas, NV 89109

Ph: (702) 254-5437 Fax: (702) 254-7354



**KANDOTH, YUSI, CRUZ, KESH,  
IBARRA, VANESSA, REARDON,  
GALGANA, MONTE, HESS**

NAME FIRST	DOB	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF SERVICE
NAME LAST	AGE	ALLERGIES	MEDICATIONS
WEIGHT (%)	HEIGHT (%)	HEAD CIRC (%)	TEMP
BLOOD PRESSURE	HEART RATE (PULSE)	PULSE OX/RESP RATE	ACCOMPANIED BY

  

<p>Reason for Visit</p> <hr/> <hr/> <p>History of Present Illness</p> <hr/> <hr/> <hr/> <hr/> <p>Past Medical History <input type="checkbox"/> Reviewed/No changes</p> <hr/> <hr/> <p>Social/Family History <input type="checkbox"/> Reviewed/No changes</p> <hr/> <hr/> <p>Immunizations <input type="checkbox"/> Reviewed/No changes</p> <hr/> <hr/> <p>Diet</p> <hr/> <hr/> <p>Elimination</p> <hr/> <hr/> <p>Sleep</p> <hr/> <hr/> <p>Behavior/Development</p> <hr/> <hr/> <p>Birth History  <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section G _____ P _____                  Birth Weight _____ Hospital _____                  Weeks of Gestation _____                  Hearing Screen _____ PKU#1 _____ HepB #1 _____                  Pregnancy Hx _____                  Delivery/Hospital Hx _____                  Other _____</p>	<p>Physical Exam KEY <input type="checkbox"/> = NORMAL <input checked="" type="checkbox"/> = ABNORMAL</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> General Appearance</td> <td><input type="checkbox"/> Abdomen</td> </tr> <tr> <td><input type="checkbox"/> Head/Fontanelle</td> <td><input type="checkbox"/> Genitalia</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red Reflex/ Strabismus/Appears to See</td> <td><input type="checkbox"/> Male Testes Down Bilaterally</td> </tr> <tr> <td><input type="checkbox"/> Ears/Appears to Hear</td> <td><input type="checkbox"/> Female</td> </tr> <tr> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Extremities/Hip (No Hip Click)</td> </tr> <tr> <td><input type="checkbox"/> Mouth/Throat</td> <td><input type="checkbox"/> Back/No Sacral Dimple</td> </tr> <tr> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Heart/Femoral Pulses</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p>Abnormal Findings/Comments:</p> <hr/> <hr/> <hr/> <hr/> <p>Assessment <input type="checkbox"/> Well Child</p> <hr/> <hr/> <hr/> <hr/> <p>Physician's Orders</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Age-Related Anticipatory Guidance/Handouts</td> <td><input type="checkbox"/> UA</td> <td><input type="checkbox"/> Influenza A and B</td> </tr> <tr> <td><input type="checkbox"/> Spirometry</td> <td><input type="checkbox"/> Strep Test</td> <td><input type="checkbox"/> Conners</td> </tr> <tr> <td><input type="checkbox"/> Tymp</td> <td><input type="checkbox"/> Lead</td> <td><input type="checkbox"/> Hgb/Hct</td> </tr> <tr> <td><input type="checkbox"/> VEP</td> <td><input type="checkbox"/> Vision RT _____ / _____, LT _____ / _____</td> <td><input type="checkbox"/> M CHAT</td> </tr> <tr> <td><input type="checkbox"/> Fluoride Varnish</td> <td></td> <td><input type="checkbox"/> RSV</td> </tr> </table> <p>Plan of Care</p> <hr/> <hr/> <hr/> <hr/> <p>Labs/Vaccinations</p> <hr/> <hr/> <hr/> <hr/> <p>Follow-up</p> <hr/> <p>Physician Signature</p> <hr/>	<input type="checkbox"/> General Appearance	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Head/Fontanelle	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Eyes/Red Reflex/ Strabismus/Appears to See	<input type="checkbox"/> Male Testes Down Bilaterally	<input type="checkbox"/> Ears/Appears to Hear	<input type="checkbox"/> Female	<input type="checkbox"/> Nose	<input type="checkbox"/> Extremities/Hip (No Hip Click)	<input type="checkbox"/> Mouth/Throat	<input type="checkbox"/> Back/No Sacral Dimple	<input type="checkbox"/> Lungs	<input type="checkbox"/> Skin	<input type="checkbox"/> Heart/Femoral Pulses	<input type="checkbox"/> Neurologic	<input type="checkbox"/> Age-Related Anticipatory Guidance/Handouts	<input type="checkbox"/> UA	<input type="checkbox"/> Influenza A and B	<input type="checkbox"/> Spirometry	<input type="checkbox"/> Strep Test	<input type="checkbox"/> Conners	<input type="checkbox"/> Tymp	<input type="checkbox"/> Lead	<input type="checkbox"/> Hgb/Hct	<input type="checkbox"/> VEP	<input type="checkbox"/> Vision RT _____ / _____, LT _____ / _____	<input type="checkbox"/> M CHAT	<input type="checkbox"/> Fluoride Varnish		<input type="checkbox"/> RSV
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