



COUNTY OF SAN DIEGO – HEALTH VISIT REPORT

PLEASE COMPLETE FOR ALL HEALTH VISITS. This information will be used to update the Health and Education Passport (HEP). Please return completed report to HEP staff by using the postpaid envelope or by fax.

PATIENT INFORMATION

CHILD'S NAME: _____ DOB: _____ CASE NO.: _____

PLEASE PRINT CLEARLY
To be completed by Health Provider

DATE OF VISIT: _____

Health Provider: _____ Phone: _____
Print or Stamp

Address: _____

VISIT TYPE:

Dental: Check-up exam X-ray Cleaning Fluoride Sealant Filling Other _____
Medical: Well Child Sick Visit Specialist Visit Other _____

DX:

ICD-9 _____
Height _____
Weight _____
Allergies _____
BMI _____

RX:

IMMUNIZATIONS: Provide date given; or attach copy of those given previously (or write dates)

IPV	DTaP	HIB	MMR	HEP B
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4		
	5			

VARICELLA	HEP A	PNEUMO-COCOAL Conjugate	Other	Other
1	1	1	Type: _____	Type: _____
2	2	2	Date: _____	Date: _____
		3	Chicken Pox disease history:	
		4	Have you ever had disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Immunized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	

TESTS GIVEN	DATE	RESULTS	TX/RX
TB/MANTOUX (PPD)		<input type="checkbox"/> Neg <input type="checkbox"/> Pos mm	
CHEST X-RAY		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
HGB		HCT %	
HCT			

Recommended Treatment/Follow-up Care:

Next appointment date: _____ Client to schedule appointment:

Referral made to: _____ Phone: _____