Iowa Child Health and Development Record

5 year Well Exam

Date________________________ **Patient #**______________
Name________________________ **Date of Birth**__________
Address____
____

Lives with: ❑ 1 parent ❑ 2 parents ❑ Other caregiver
❑ Others (including siblings)________________________
____

May release information to: (parent, guardian, other family -- list)__________________
____

Parental concerns: __________________________
Changes in child's health since last visit:______________
____

GENERAL HEALTH:

Nutrition/Dental:

YES	NO	
❑	❑	Pacifier or thumb?____
❑	❑	Cow's milk____oz/day
❑	❑	Juice ____oz/day
❑	❑	Daily eats all food groups, incl. fruits and vegies
❑	❑	**Twice daily brushing of teeth**
❑	❑	**Has had twice yearly dental visit**

Elimination: ❑ Stooling: soft, easy to pass BMs__________
Sleep:____hours through the night

YES	NO	
❑	❑	Problems? Eat during the night?____________

____

DEVELOPMENT: Screen or refer if concerns or "No" response on milestones in **bold type.**

YES	NO	
❑	❑	**Family reports child can do what most 5-year-olds can do**
❑	❑	**Dresses self**
❑	❑	**Communicates easily with others; ablle to tell a story**
❑	❑	**Able to follow directions**
❑	❑	**Knows 4 or more colors**
❑	❑	May know some letters and numbers
❑	❑	**Draws a person with 3-6 body parts**
❑	❑	**Balances on each foot for 4 seconds, hops**

Family concerns about behavior, speech, learning, social, or motor skills:________________________________
____

MEDICAL HISTORY:

Medications:____________Allergies:____________________
Major medical illnesses:______________________________
____
Hospitalizations______________________________________
____
Surgeries:____

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare/after school care: ______________________________

Attends: ❑ preschool ❑ kindergarten

FAMILY RISK FACTORS:

Changes in family since last visit:______________________________
____

Stress: How much stress are you and your family under now?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

What kind of stress? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ Violence/Abuse ❑ Lack of help ❑ Financial
❑ Health Insurance ❑ Child care ❑ Other ____________

How stressful is caring for your child?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless? ❑ No ❑ Sometimes ❑ **Often**

In the past month have you/partner felt little interest or pleasure in doing things? ❑ No ❑ Sometimes ❑ **Often**

ANTICIPATORY GUIDANCE: ❑ Check if discussed

FAMILY WELL-BEING:

- ❑ Promote physical activity; limit screen time <2h, monitor content
- ❑ Show affection in the family & model respect for all people.
- ❑ Discuss anger & anger management & praise efforts for self-control
- ❑ Family meals, maintain bedtime routine, including reading
- ❑ Have family rules, chores; Praise accomplishments, establish consequences for not following rules

BEHAVIOR / DEVELOPMENT / SCHOOL READINESS:

- ❑ Talk about new experiences, friends, activities
- ❑ Visit school & playground, meet teacher. After-school care?
- ❑ Discuss possibility of bullying, or kids being "mean"

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Ensure good breakfast at home or at school.
- ❑ Balanced diet , healthy choices for snacks.
- ❑ Observe good hygiene, hand-washing.
- ❑ Supervise brushing, help with flossing
- ❑ Dental exams every 6 mo

SAFETY:

- ❑ Not yet ready to monitor own street crossing or safety.
- ❑ School bus safety and rules.
- ❑ **All** wheeled activity requires wearing well-fitting helmet: biking, skating, using scooters.
- ❑ Booster seat in back seat.
- ❑ Teach home and emergency phone numbers, home address; home fire escape plan.
- ❑ Teach safety with adults - **No** adult should:
  - tell child to keep secrets from parents
  - express interest in private parts
  - ask child for help with private parts
- ❑ If smoking in home: discuss quitting, limiting exposure

Iowa Child Health and Development Record

5 year Well Exam

PHYSICAL EXAMINATION

Vital signs: P: _______R: ________T: ________ BP_____/_____Weight______(________%) Height_____(_____%)

BMI__________ (__________%) Vision screening: R 20/__________L 20/______ Hearing: R______L_________

N Abn *Comment on abnormal findings*

❑ ❑ General appearance________________________________

❑ ❑ Behavior/interaction with family________________________________

❑ ❑ Skin________________________________

❑ ❑ Head/scalp________________________________

❑ ❑ Ears________________________________

❑ ❑ Eyes________________________________

❑ ❑ Nose________________________________

❑ ❑ Mouth/Throat ________________________________

❑ ❑ Teeth________________________________

❑ ❑ Neck ________________________________

❑ ❑ Back/Chest________________________________

❑ ❑ Lungs________________________________

❑ ❑ Heart________________________________

❑ ❑ Abdomen________________________________

❑ ❑ Genitalia ________________________________

❑ ❑ Musculoskeletal________________________________

❑ ❑ Neurologic ________________________________

Results reviewed: (outside info, lab, etc.)________________________________

Impression:________________________________

____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations:

❑ Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: ❑ No ❑ Yes________________________________

See current guidelines www. immunize.org/aap

LAB: ❑ Lead: Assess risk ❑ Hb or Hct: Assess risk ❑ other if indicated__________________________

Referral: (if indicated)________________________________

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229
Developmental delay or disability: **Check with local public school**

Handouts:________________________________

Return appointment:________________________________

Signature ________________________________ Date _______________