Iowa Child Health and Development Record

6 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	
❑	❑	3 servings of milk?
❑	❑	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

Problems? ❑ **YES** ❑ **NO**

_____

DEVELOPMENT:

School: Grade_____

Favorite subject of activity:_____

Problems: ❑ **YES** ❑ **NO**_____

YES	NO	
❑	❑	Early reading
❑	❑	Able to tell print numbers to 10, write name, know L / R
❑	❑	Ties shoes
❑	❑	Rides bike
❑	❑	Following directions, begins to impose and follow rules

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

Activities outside of school:_____

Peer relations: ❑ **GOOD** ❑ **OK** ❑ **POOR**

MEDICAL HISTORY:

Medications/supplements:_____

Allergies:_____

Major medical illnesses:_____

Hospitalizations_____

Surgeries:_____

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare/after school care: _____

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 only if discussed

FAMILY WELL-BEING:

- ❑ Family fitness; limit screen time <2h, monitor content.
- ❑ Show affection in the family & model respect for all people.
- ❑ Discuss anger management, praise efforts for self-control.
- ❑ Family meals, maintain bedtime routine, including reading.
- ❑ Family rules, chores; Praise accomplishments.

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Ensure good breakfast at home or at school.
- ❑ Balanced diet – fruits/veget, whole grains, healthy snacks
- ❑ Observe brushing, help floss. Dental exams every 6 months

BEHAVIOR:

- ❑ **School:** talk about new experiences, friends, activities, possibility of bullying, or kids being "mean".
- ❑ Visit school & playground, meet teacher. After-school care?
- ❑ Clearly state expectations and consequences –no threats, but consistently follow through with consequences
- ❑ Encourage child to make choices. Listen to child respectfully – will help in developing autonomy, independence
- ❑ Answer child's questions about sex, drugs in a straightforward manner with as much or as little info as child needs

SAFETY:

- ❑ School bus safety and rules.
- ❑ **All** wheeled activity requires wearing well-fitting helmet:
- ❑ Booster seat in back seat. until ~4'9" tall, shoulder strap across shoulder, not neck, can bend at knees while sitting against seat back
- ❑ 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.

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ BP_____/_____Weight_____(_____%) Height_____(_____%)

BMI_____ (_____%) Vision screening: R 20/_____L 20/_____ Hearing: R_____L_____ (objective test)

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 _____

Sexual Maturity Stage ___ breast (female) ___ genitals (male) ___ pubic hair (female & male)

❑ ❑ 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 ❑ TB: Assess risk

❑ Lipid: 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

For referral of children with developmental delay or educational concerns ***3 yr through high school:***
local **Iowa Area Education Agency** **www.iowaaea.org**

Handouts:_____

Return appointment:_____

Signature _____ Date _____