Iowa Child Health and Development Record

9-10 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	
❑	❑	3-4 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	
❑	❑	Reading and math at grade level?
❑	❑	Improving motor skills, team sports
❑	❑	Handles frustrations and anger appropriately
❑	❑	Understands family and school rules, and consequences of not following

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:

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 meal, positive interactions No TV during meals or in bedrooms
- ❑ Household chores, responsibilities – respect privacy of each member of the family
- ❑ Media limitation; monitor computer use, install safety filter ; promote "media literacy"
- ❑ Model admitting mistakes, asking forgiveness, dealing with anger or disagreements

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Eat breakfast! Water rather than soda or juice
- ❑ Avoid junk food – eat healthy snacks.
- ❑ Brush twice, floss once. Dental exams every 6 months

BEHAVIOR:

- ❑ Discuss school, activities; needs quiet space for homework
- ❑ Discuss puberty, increase in personal hygiene
- ❑ Discuss tobacco, alcohol, other drugs
- ❑ Consistent expectations and consequences , balanced with plenty of affection and positive reinforcement.–
- ❑ Expect some early adolescent behavior – challenges to rules, conflicts over independence, refusal to participate with family

SAFETY:

- ❑ Helmet and other protective sports equipment –
- ❑ Pedestrian street safety
- ❑ Know friends & their families, cont to need supervision
- ❑ Make plan for personal safety if feels unsafe
- ❑ Stranger safety – don't answer phone, door alone; before and after school supervision
- ❑ Water safety , including flotation device if in boat
- ❑ Gun safety (including b.b. guns)
- ❑ Check smoke & CO detectors regularly
- ❑ 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: ❑ Lipid screening ❑ Hb or Hct: Assess risk ❑ TB: 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 _____