Iowa Child Health and Development Record

4 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? ______________________________

____

DEVELOPMENT:

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

YES	NO	
❏	❏	**Family reports child can do what most 4-year-olds can do**
❏	❏	**Plays games with other children***
❏	❏	**Dresses self with help**
❏	❏	**Speaks in sentences***
❏	❏	**Speech is understandable to strangers**
❏	❏	**Understands "on" "under" "big" "little"**
❏	❏	**Copies a circle**
❏	❏	**Balances on each foot for 2 seconds**

(***autism risk**)

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: ____

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:

- ❏ Limit screen time < 2 hours per day – Monitor programming.
- ❏ No TV or DVD in bedrooms.
- ❏ Family physical and educational activities – museums, zoos, community projects.
- ❏ Structure quiet bed time routine. Read or tell stories

BEHAVIOR:

- ❏ Discuss feelings and experiences, praise when sensitive to others' feelings
- ❏ Observe child's interactions with peers, offer suggestions, and model appropriate actions.
- ❏ Encourage and ask questions - respond with short, simple, factual answers
- ❏ Set appropriate limits, praise good behavior and accomplishments.
- ❏ Assign simple chores (picking up toys, setting table).
- ❏ Structured learning/play opportunities- preschool, playgroups, Sunday school, etc.
- ❏ Teach child correct terms regarding bodies, explain privacy, discuss "rules" of behavior re: adults

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❏ 5+ fruits & vegetables, 3+ low-fat milk / dairy, limit junk food, NO soft drinks.
- ❏ Model good eating habits, Family meal.
- ❏ Brush twice daily with Fl toothpaste, have family dental home

SAFETY:

- ❏ Teach safety with adults - No adult should: tell child to keep secrets from parents; express interest in private; ask child for help with private parts.
- ❏ Review matches, lighters, guns.
- ❏ Teach pet, neighborhood, street, stranger safety, but **supervise** all activity near streets and driveways.
- ❏ Swimming lessons don't guarantee safety, keep within arms' length.
- ❏ 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 ____

❑ ❑ 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 ❑ Lipid: 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 developmental delay or disability: **Check with local public school**

Handouts:____

Return appointment:____

Signature ____ Date ________________