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? _____

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

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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 ❑ 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

Developmental delay or disability: **Check with local public school**

Handouts:_____

Return appointment:_____

Signature _____ Date _____