Iowa Child Health and Development Record

7-8 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	
❑	❑	Reading: types - early readers, chapter books
❑	❑	Improving motor skills, enjoys team sports
❑	❑	Ties shoes, writes legibly
❑	❑	Imposes rules on games, understands intentional versus accidental

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 outings, family meal, positive interactions, individual undivided attention
- ❑ Media limitation, monitor content – help become "media literate" by watching with children and commenting on messages
- ❑ Household chores, responsibilities for all

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Be sure has healthy breakfast (3 meals per day); healthy snacks.
- ❑ No soda, <6 oz juice; >2 cups skim milk (or low-fat daily)
- ❑ Observe twice daily brushing, help floss, Dental exams q 6 mo
- ❑ Mouth guard with contact sports

BEHAVIOR:

- ❑ Discuss school, activities, interests, friends. Any bullying?
- ❑ Talk about feelings, worries
- ❑ Encourage competence/independence
- ❑ Answer child's questions about sex, drugs simply with as much or as little info as child needs

SAFETY:

- ❑ Booster seat until ~4'9" tall, shoulder strap across shoulder-not neck, can bend at knees while sitting against seat back
- ❑ ALWAYS wear helmet with wheeled activities.
- ❑ Teach danger of driveways. Still shouldn't ride alone in street
- ❑ Know child's friends and families, agree on supervision
- ❑ Fire safety-family escape plan, practice it. Water safety-learning how to swim does NOT insure safety; sunscreen
- ❑ Stranger safety – don't answer phone, door alone; before and after school supervision
- ❑ Gun safety (including BB guns)
- ❑ 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: ❑ 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 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 _____