

Name				Accompanied by	
Date	MRN	Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Preferred Language	

ATTACH LABEL

CAREGIVER CONCERNS/INTERVAL HISTORY: None

- PAST MEDICAL HISTORY** Reviewed and updated
- SURGICAL HISTORY** Reviewed and updated
- FAMILY HISTORY** Reviewed and updated
- MEDICATIONS** None
 Reviewed and updated
- ALLERGIES** No known drug allergies

Nutrition: Varied diet, including fruits & vegetables

Iron-rich food Yes No _____

Milk _____ (three servings per day)
 whole 2% skim other _____

Water _____

Juice _____ oz/day

Other liquids _____

Dental: Twice daily oral health care _____

Has had twice yearly dental visit _____

Fluoride in water at home _____

Elimination: YES NO

Soft, easy to pass BMs _____

Issues with constipation _____

Normal urine stream _____

Sleep: YES NO

Total sleep hours including nap time _____

Put to bed awake at night and naps _____

Snoring

occasional

more than three days/week
(high risk for sleep apnea)

Risk Assessment

- | | | |
|-----------------------|-----------------------|-------------------------|
| HIGH | LOW | |
| <input type="radio"/> | <input type="radio"/> | Anemia _____ |
| <input type="radio"/> | <input type="radio"/> | TB _____ |
| <input type="radio"/> | <input type="radio"/> | Lead Exposure _____ |
| <input type="radio"/> | <input type="radio"/> | Dyslipidemia Risk _____ |

DEVELOPMENT:

- | | | |
|-----------------------|-----------------------|-------------------------------------|
| YES | NO | |
| <input type="radio"/> | <input type="radio"/> | Early reading |
| <input type="radio"/> | <input type="radio"/> | Dry day and night |
| <input type="radio"/> | <input type="radio"/> | Counts 10 or more objects |
| <input type="radio"/> | <input type="radio"/> | Tells a story |
| <input type="radio"/> | <input type="radio"/> | Draws a person with 12 body parts |
| <input type="radio"/> | <input type="radio"/> | Writes name |
| <input type="radio"/> | <input type="radio"/> | Hops on one foot |
| <input type="radio"/> | <input type="radio"/> | Initiates conversation with friends |
| <input type="radio"/> | <input type="radio"/> | Plays well with at least one friend |
| <input type="radio"/> | <input type="radio"/> | Able to ride a bike |

Caregiver concerns about development and behavior:

SCHOOL

School Grade: _____ Favorite subject/activity: _____

Concerns about school experience: Yes No _____

Extra education services through the school: Yes No _____

Activities outside of school: _____

Peer relations: Good Okay Poor

SOCIAL HISTORY:

Reviewed and updated

Lives with: 1 parent 2 parents Other caregiver

Others (including siblings):

FAMILY RISK FACTORS:

Changes in family since last visit:

ATTENDS: Preschool Kindergarten

Do you need additional assistance with any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Getting enough to eat | <input type="checkbox"/> Relationships | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Violence/Abuse | <input type="checkbox"/> Financial | <input type="checkbox"/> Alcohol abuse |

PHYSICAL EXAMINATION

Height _____ cm		Weight _____ kg		BMI _____ kg/m ²	
VITALS:	Temp: _____	BP ____/____ ____/____%ile	HR: _____	Resp Rate: _____	SpO ₂ _____
Hearing Screen:	Left: (pass/fail)	Right: (pass/fail)			
Vision Screen:	Left: _____	Right: _____	Bilateral: _____		

Normal examination findings below. Describe other findings in the area provided.

General: Well appearing, active, and alert. _____

Head: Normocephalic and atraumatic. _____

Eyes: Red reflex, present bilaterally. Pupils equal, round, and reactive to light. No discharge. _____

ENT: No ear deformities. Normal external canals. Tympanic membranes clear bilaterally. Nares patent. _____

Mouth: No oral lesions. Normal dentition. _____

Neck: Supple, with full range of motion. _____

Cardiovascular: Regular rate and rhythm. Heart sounds S1, S2 normal. No murmur. _____

Chest: No increased work of breathing. Clear and symmetric breath sounds bilaterally. _____

Abdomen: Soft, non-distended, no masses, no hepatosplenomegaly. Normal appearing external anus. _____

Genitourinary:

Normal female external genitalia. _____

Normal male external genitalia. Testes descended bilaterally, no scrotal swelling. _____

Musculoskeletal: Spine normal. Moves all extremities symmetrically. _____

Neurological: Normal strength and tone. _____

Skin: Normal color. No lesions. _____

Other comments:

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ANTICIPATORY GUIDANCE:

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/DEVELOPMENT/SCHOOL:

- School: talk about new experiences, friends, activities, possibility of bullying, or kids being “mean”.
- Visit school & playground, meet teacher
- 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:

- All wheeled activity requires wearing a 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.

ASSESSMENT

Well Child Exam

- Normal findings
(normal interval growth, age appropriate development)
- Abnormal findings _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations:

- Vaccine Information Statements Given
- Vaccine counseling given
- Vaccines due: Influenza COVID-19
- Catch-up vaccinations given
 - Hep A Varicella
 - Hep B DTaP
 - MMR Polio

- High risk: MenACWY-CRM (Menveo) ≥2 mos
 MenACWY-D (Menactra) ≥9 mos
 PPSV23 ≥2 yrs

Past adverse reactions to immunizations:

- No Yes _____

See **current guidelines:** <https://www.cdc.gov/vaccines/index.html>

- LAB if indicated:** Lead Hb or Hct Lipid Screening
 other _____
 TB testing if high risk _____

Developmental Follow-up:

- No delays Follow-up in office Referral

5-2-1-0: Healthy choices framework. For more information: iowahealthieststate.com/resources/individuals/5210/

Healthy Families Line: For assistance with care coordination, transportation, or health information for children birth through age 21, call (800) 369-2229

Area Education Agencies: For development or educational concerns contact your local AEA. www.iowaaea.org/

Return appointment:

- Follow-up in 12 months _____
 Other/referral based on risk assessment _____

ATTACH LABEL

Signature _____ Date _____

NOTES

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