

Well Child Exam

Toddler: 3 Years



3 years

Date								
Patient Name				DOB	Sex	Parent Name		
Allergies				Current Medications				
Prenatal / Family History					Ethnicity			
Weight	Percentile	Height	Percentile	BMI	Temp.	Pulse	Resp.	BP
	%		%					

Interval History (include injury/illness, visits to other health care providers, changes in family or home) _____ _____
Nutrition <input type="checkbox"/> Grains _____ servings per day <input type="checkbox"/> Vegetables _____ servings per day <input type="checkbox"/> Fruits _____ servings per day <input type="checkbox"/> Milk _____ servings per day <input type="checkbox"/> Meat/Beans _____ servings per day <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Fluoride prescribed
Elimination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep <input type="checkbox"/> Normal (8-12 hours) <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page
Screening Hearing <input type="checkbox"/> Screening audiometry (optional) <input type="checkbox"/> Responds to noisemaker (optional) <input type="checkbox"/> Parental observation/concerns Vision <input type="checkbox"/> Can see small objects <input type="checkbox"/> Ocular alignment <input type="checkbox"/> Visual acuity _____R _____L _____Both <input type="checkbox"/> Parental observation/concerns Lead Poisoning <i>If not previously tested:</i> Test date _____ <input type="checkbox"/> Lead level _____ mcg/dl (required for Medicaid) If Risk: <input type="checkbox"/> IPPD _____ (result) <input type="checkbox"/> Hct or Hgb _____ (result) <input type="checkbox"/> Cholesterol _____ (result)
Immunizations <input type="checkbox"/> Immunizations Reviewed, Given & Charted – <i>if not given, document rationale</i> <input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Flu if high risk <input type="checkbox"/> Pneumonia if high risk
WIC <input type="checkbox"/> Y <input type="checkbox"/> N
Developmental Questions and Observations on Page 2
Next Well Check: 4 years of age
Provider Signature: _____

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N				
Review of Symptoms		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N Plan <input type="checkbox"/> History/Problem List/Meds Updated <input type="checkbox"/> Referrals <input type="checkbox"/> WIC <input type="checkbox"/> Head Start <input type="checkbox"/> Transportation <input type="checkbox"/> Children Special Health Care Needs <input type="checkbox"/> Priority Health Case Mgmt 800 998-1037 <input type="checkbox"/> Other _____				

Anticipatory Guidance / Health Education (✓ if discussed)
Healthy and Safe Habits
Injury and Illness Prevention <input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Teach child to wash hands, wipe nose w/tissue <input type="checkbox"/> Limit TV, watch programs together <input type="checkbox"/> Reinforce bedtime routine <input type="checkbox"/> Fires/burns/test smoke alarms <input type="checkbox"/> Appropriate car seat placed in back seat <input type="checkbox"/> Pool/tub/water safety <input type="checkbox"/> Use bike helmet <input type="checkbox"/> Teach stranger safety <input type="checkbox"/> Childproof home (matches, guns, medicines) <input type="checkbox"/> Supervise play, ensure playground safety <input type="checkbox"/> Teach pedestrian safety
Nutrition <input type="checkbox"/> Limit sweets <input type="checkbox"/> Serve low-fat dairy products <input type="checkbox"/> Offer variety of healthy foods, let child decide
Oral Health <input type="checkbox"/> Schedule dental appointment <input type="checkbox"/> Teach child to brush teeth
Sexuality Education <input type="checkbox"/> Expect normal curiosity <input type="checkbox"/> Explain certain body parts are private
Social Competence <input type="checkbox"/> Reinforce limits, provide choices <input type="checkbox"/> Encourage talking and reading <input type="checkbox"/> Encourage safe exploration <input type="checkbox"/> Praise good behavior and accomplishments <input type="checkbox"/> Help child cope with fears
Family Support and Relationships <input type="checkbox"/> Show affection, spend time with each child <input type="checkbox"/> Create family time together <input type="checkbox"/> Substance abuse/domestic violence <input type="checkbox"/> Handle anger constructively, help siblings resolve conflicts <input type="checkbox"/> Choose responsible caregivers
Community Interaction <input type="checkbox"/> Discuss community programs, preschool, Head Start, parenting groups

Date	Patient Name	DOB
------	--------------	-----

Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes No

 Please tell me any concerns about the way your toddler is behaving or developing:

-
- My child is able to play by him/herself for short periods of time.
 - My child is able to leave me when in a known place.
 - My child can tell when others are happy, mad, or sad.
 - My child copies a circle and a cross.
 - My child eats a variety of foods.
 - My child knows his/her name, age, and sex.
 - My child can jump off a step with both feet.

Ask the parent to respond to the following statements:

Yes No

- I have people who assist me when I have questions or need help.
- I am enjoying my time with my child.
- I have time for myself, partner, and friends.
- I feel safe with my partner.
- I feel confident in parenting.

Provider to follow up as necessary.

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Child Development			Parent Development		
Dresses self	Yes	No	Appropriately disciplines toddler	Yes	No
Rides a tricycle	Yes	No	Parent is loving toward child	Yes	No
My family understands my child's speech	Yes	No	Positively talks, listens, and responds to child	Yes	No
Shows little or no preference for parent or caregiver	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Seeks comfort from parent when upset	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (<i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i>)		

Additional notes from pages 1 and 2:

Staff Signature: _____ **Provider Signature:** _____

This HME form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Association of Health Plans, and Michigan Association of Local Public Health. Adapted with permission by Priority Health 9/06.

Patient Education:

Your Child's Health at 3 Years

Milestones: Ways your child is developing between 3 and 4 years of age

- Can sing a song
- Learning to share
- Talks about what he/she did during the day
- Can hop, jump on one foot
- Rides a tricycle or a bicycle with training wheels
- Knows his/her first and last name
- Begins to test limits
- Shows a silly sense of humor
- Throws a ball overhand
- Tries to draw a person with 3 parts (such as head, body, legs)
- Knows what is real and what is pretend
- Builds towers of 9-10 blocks

Safety Tips

- Check your home for dangers often. Your child is not old enough to stay away from things that could harm him/her, like matches, guns, and poisons. Lock them up!
- Continue using a car seat until your child weighs 40 pounds. After that, use a booster seat up to about 80 pounds. Keep your child in the back seat.
- Make sure your child uses a helmet whenever he/she rides a tricycle, scooter, or other toys with wheels.

Health Tips

- Your child still needs about two cups of milk every day. Offer a variety of fruits and vegetables daily. Water is a healthy drink, so offer it instead of sweetened drinks.
- Help your child brush his/her teeth every day with a pea-sized amount of fluoride toothpaste. Make sure your child gets a dental checkup once a year.
- Teach your child to wash his/her hands well after playing and using the toilet, and before eating. Use soap and rub hands together for about 20 seconds.
- Each child develops in his or her own way, but you know your child best. If you think he/she is not developing well, you can get a free screening. Call your child's doctor or nurse if you have questions.

Parenting Tips

Children learn best by doing. They need to:

- Play active games (tag, ball, riding wheeled toys, climbing).
- Play imagination games (using dolls, figure toys, story books).
- Play with toys that use their hands (blocks, big puzzles).
- Limit television and computer time to less than one hour a day.

Help your child feel good about himself and others:

- Praise your child every day.
- Encourage your child's new friendships.
- Be consistent and clear about your child's behaviors that are okay or not okay.
- Use discipline to teach and protect your child, not to punish her or make her feel bad about herself.
- Help your child "use his words" when having a disagreement instead of hitting, kicking, biting, or saying mean things.

When you are a parent you will be happy, mad, sad, frustrated, angry, and afraid, at times. This is normal.

If you feel very mad or frustrated:

- Make sure your child is in a safe place and walk away.
- Call a good friend to talk about what you are feeling.
- Call the Parent Helpline at 800 942-4357 (in Michigan). It's free! They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

For Help or More Information

Priority Health

Customer Service 616 942-1221 or 800 446-5674
Medicaid 888 975-8102
Behavioral Health 616 464-8500 or 800 673-8043
priorityhealth.com

Domestic Violence

National Domestic Violence Hotline
800 799-SAFE (7233)

Health and Nutrition Program

Women, Infant, and Children (WIC) Program
800 262-4784

LA LECHE League 847 519-7730
www.lalecheleague.org

Special Health Care Needs

Children Special Health Care Services,
MDCH Family 800 359-3722

Childhood Development

Early On Michigan 800 327-5966
Michigan Head Start Association 517 374-6472

Parenting Skills or Support

Parents Hotline 800 942-4357
Family Support Network of Michigan
800 359-3722

Childcare

Child Care Licensing Agency, Michigan Department
of Consumer & Industry Services
517 373-8300

Childhood Immunizations

National Immunization Program Hotlines
800 232-2522 (English) or 800 232-0233 (Spanish)

Lead Screening

Michigan Department of Community Health Hotline
800 648-6942

Prevention of Unintentional Childhood Injuries

National Safe Kids Campaign 202 662-0600
www.safekids.org

Car Seat and Booster Safety

Auto Safety Hotline 888 327-4236

Poison Prevention

Call the Poison Control Center
800 222-1222