

Well Child Exam

Early Childhood: 5 Years



5 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 <input type="checkbox"/> Abnormal
Screening Hearing <input type="checkbox"/> Screening audiometry <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 Procedures <input type="checkbox"/> Urinalysis (Required for Medicaid) If Risk: <input type="checkbox"/> IPPD _____ (result) <input type="checkbox"/> Hct or Hgb _____ (result) <input type="checkbox"/> Cholesterol _____ (result) <input type="checkbox"/> Lead level _____ mcg/dl (required for Medicaid) Test date _____
Immunizations <input type="checkbox"/> Immunizations Reviewed, Given, & Charted – if not given, document rationale <input type="checkbox"/> MCLR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Flu if high risk <input type="checkbox"/> Pneumonia if high risk
Developmental Questions and Observations on Page 2
Next Well Check: 6 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"/> Dental <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 <input type="checkbox"/> Teach child to wash hands, wipe nose w/tissue <input type="checkbox"/> Limit TV, video, and computer games <input type="checkbox"/> Physical activity & adequate sleep
Injury and Illness Prevention <input type="checkbox"/> Fires/burns/test smoke alarms <input type="checkbox"/> Appropriate booster seat placed in back seat <input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Pool/tub/water safety – swimming lessons <input type="checkbox"/> Use bike/skating helmet <input type="checkbox"/> Supervise near pets, mowers, driveways, streets <input type="checkbox"/> Limit time in sun use hat/sunscreen
Nutrition <input type="checkbox"/> Family meals <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 <input type="checkbox"/> Discuss flossing, fluoride, sealants
Sexual Development and Education <input type="checkbox"/> Expect normal curiosity of genitalia & sex <input type="checkbox"/> Explain good touch/bad touch and that certain body parts are private
Social Competence <input type="checkbox"/> Reinforce limits, provide choices <input type="checkbox"/> Continue to read and sing with your child <input type="checkbox"/> Simple household tasks & responsibilities <input type="checkbox"/> Praise good behavior and actions <input type="checkbox"/> Family rules/respect/right from wrong <input type="checkbox"/> Encourage expression of feelings
Family Support and Relationships <input type="checkbox"/> Listen/respect/show interest in activities <input type="checkbox"/> Eat meals as a family <input type="checkbox"/> Substance abuse, domestic violence, depression
Community Interaction <input type="checkbox"/> Discuss community and recreational programs, school, and after school care <input type="checkbox"/> Volunteer and become involved with school <input type="checkbox"/> Meet your child's school teachers

Date	Patient Name	DOB
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Developmental Questions and Observations

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

Yes No

My Please tell me any concerns about the way your child is behaving or developing.

- My child does what I ask them to do most of the time.
 My child says positive things about him/her.
 My child shows an ability to understand the feelings of others.
 My child enjoys pretend play.
 My child eats a variety of foods.
 My child can recognize most letters and is able to print some letters.
 My child can balance on one foot.

Ask the parent to respond to the following statements:

Yes No

- I have people I can turn to when I have questions or need help.
 I feel good about my child starting school.
 I am sad more often than I am happy.
 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 without supervision	Yes	No	Appropriately disciplines child	Yes	No
Skips and walks on tiptoe	Yes	No	Parent is loving toward child	Yes	No
Draws a person with head, body, arms, and legs	Yes	No	Positively talks, listens, and responds to child	Yes	No
Appears unusually fearful, anxious or withdrawn	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Aggressive or destructive behavior that threatens, harms, or damages people, animals, or property	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>)		
Displays negativity, low self-esteem, or extreme dependence	Yes	No			

Additional notes from pages 1 and 2:

Family History Update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who _____ what age _____
 New medical diagnosis: who _____ what age _____
 Anything else in your family history you have concerns or questions with: (Refer to Family History form)

Staff Signature: _____ Provider Signature: _____

Patient Education:

Your Child's Health at 5 Years

Milestones: Ways your child is developing between 5 and 6 years of age

- Recognizes his/her own printed name
- May form special groups of friends, may be jealous of others
- Takes turns, helps with family chores
- Feels proud of self and accomplishments
- Able to follow rules at home and school and respect authority
- Beginning to learn rules for simple games, learning to swim

Safety Tips

- Booster car seats are for big kids! Use a booster in the back seat with lap/shoulder belts until your child is tall enough for adult seat belts.
- Your child should always wear a life jacket around water, even after he/she has learned to swim.
- Always watch your child closely when he/she is near the street. Children are not ready to ride bikes safely on streets or cross streets without an adult until they reach at least age 9. Your child is not old enough to always behave safely around vehicles.
- Teach your child to never touch a gun. If he/she finds one, he/she should tell an adult right away. Make sure any guns in your home are unloaded and locked up.

Health Tips

- Continue to take your child for a check-up each year. After getting all the “shots” needed for school, he/she probably won’t need more “shots” until age 11 or 12.
- Your child will need help brushing his/her teeth well. Make sure to take him/her for a dental check-up at least once a year.

Parenting Tips

- Eat together as often as possible. Turn off the TV, unplug the phone, and enjoy each other.
- Listen when your child talks to you. Look at him/her and pay attention. Then answer or ask about their ideas. Let him/her know that what they think and say is important to you.
- Talk with your child about how to avoid sexual abuse. Teach him/her about privacy and that some touching is not right. Tell him/her they should say “no” and that they should tell you if anyone tries to harm them.
- Limit TV or computer time so your child also has time for books and active play. Read storybooks with him/her daily. Take your child outside often to play.
- Help your child feel good about himself and others:
 - o Praise your child every day
 - o Be clear about behaviors that are okay or not okay
 - o Help your child use words to tell about their feelings

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:

- If you feel very mad or frustrated with your child, make sure your child is in a safe place and walk away.
- Call a friend to talk about what you are feeling.
- Call the free Parent Helpline at 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day.

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)

Child Abuse and Neglect Information Hotline

800 942-4357

Michigan Coalition Against Domestic &
Sexual Violence

517 347-7000

Parenting Skills or Support

Parents Hotline 800 942-4357

Family Support Network of Michigan

800 359-3722

Prevention of Unintentional Childhood Injuries

National Safe Kids Campaign

Safe Gun Storage Information

202 662-0600

www.safekids.org

Fire Safety

Talk with firefighters at your local fire station

Poison Prevention

Call the Poison Control Center

800 222-1222