

Well Child Exam



Child: 5 years

| | | | | | | | | | |
|-------------------------|------------|--------|------------|-----|---------------------|-------|-------------|-------|----|
| Date | | | | | | | | | |
| Patient name | | | | DOB | | Sex | Parent name | | |
| Allergies | | | | | Current medications | | | | |
| Prenatal/family history | | | | | | | Ethnicity | | |
| Weight | Percentile | Height | Percentile | BMI | Percentile | Temp. | Pulse | Resp. | BP |
| | % | | % | | % | | | | |

| |
|---|
| <p>Interval history</p> <p>(include injury/illness, visits to other health care providers, changes in family or home)</p> <p>_____</p> <p>_____</p> |
| <p>Nutrition</p> <p><input type="checkbox"/> Grains _____ servings per day</p> <p><input type="checkbox"/> Vegetables _____ servings per day</p> <p><input type="checkbox"/> Fruits _____ servings per day</p> <p><input type="checkbox"/> Milk _____ servings per day</p> <p><input type="checkbox"/> Meat/beans _____ servings per day</p> <p><input type="checkbox"/> City water <input type="checkbox"/> Well water</p> <p><input type="checkbox"/> Bottled water <input type="checkbox"/> Fluoride prescribed</p> |
| <p>Elimination</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> |
| <p>Sleep</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> |
| <p>Screening</p> |
| <p>Hearing</p> <p><input type="checkbox"/> Screening audiometry</p> <p><input type="checkbox"/> Parental observation/concerns</p> |
| <p>Vision</p> <p><input type="checkbox"/> Can see small objects <input type="checkbox"/> Ocular alignment</p> <p><input type="checkbox"/> Visual acuity ___R ___L ___Both</p> <p><input type="checkbox"/> Parental observation/concerns</p> |
| <p>Procedures</p> <p><input type="checkbox"/> Urinalysis (required for Medicaid)</p> <p>If Risk: <input type="checkbox"/> IPPD _____ (result)</p> <p><input type="checkbox"/> Hct or Hgb _____ (result)</p> <p><input type="checkbox"/> Cholesterol _____ (result)</p> <p><input type="checkbox"/> Lead level ___ mcg/dl (required for Medicaid)</p> <p>Test date _____</p> |
| <p>Immunizations</p> <p><input type="checkbox"/> Immunizations reviewed, given & charted – if not given, document rationale</p> <p><input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given</p> <p><input type="checkbox"/> Flu if high risk <input type="checkbox"/> Pneumonia if high risk</p> |
| <p>Developmental questions and observations on page 2</p> |
| <p>Next Well Check: 6 years of age</p> |
| <p>Provider signature:</p> |

Patient unclothed Y 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 |

Abnormal findings and comments
If yes, see additional note area on next page

Results of visit discussed with parent Y N

Plan

History/problem list/meds updated

Referrals

Dental Transportation

Children Special Health Care Needs

Priority Health Case Mgmt 800 998-1037

Other _____

| |
|---|
| <p>Anticipatory guidance/health education (/ if discussed)</p> |
| <p>Healthy and safe habits</p> <p><input type="checkbox"/> Teach child to wash hands, wipe nose w/tissue</p> <p><input type="checkbox"/> Limit TV, video and computer games</p> <p><input type="checkbox"/> Physical activity and adequate sleep</p> |
| <p>Injury and illness prevention</p> <p><input type="checkbox"/> Fires/burns/test smoke alarms</p> <p><input type="checkbox"/> Appropriate booster seat placed in back seat</p> <p><input type="checkbox"/> Keep home and car smoke-free</p> <p><input type="checkbox"/> Pool/tub/water safety - swimming lessons</p> <p><input type="checkbox"/> Use bike/skating helmet</p> <p><input type="checkbox"/> Supervise near pets, mowers, driveways, streets</p> <p><input type="checkbox"/> Limit time in sun, use hat/sunscreen</p> |
| <p>Nutrition</p> <p><input type="checkbox"/> Family meals</p> <p><input type="checkbox"/> Offer variety of healthy foods, let child decide</p> |
| <p>Oral health</p> <p><input type="checkbox"/> Schedule dental appointment</p> <p><input type="checkbox"/> Teach child to brush teeth</p> <p><input type="checkbox"/> Discuss flossing, fluoride, sealants</p> |
| <p>Sexuality education</p> <p><input type="checkbox"/> Expect normal curiosity of genitalia and sex</p> <p><input type="checkbox"/> Explain good touch/bad touch and that certain body parts are private</p> |
| <p>Social competence</p> <p><input type="checkbox"/> Reinforce limits, provide choices</p> <p><input type="checkbox"/> Continue to read and sing with your child</p> <p><input type="checkbox"/> Simple household tasks and responsibilities</p> <p><input type="checkbox"/> Praise good behavior and actions</p> <p><input type="checkbox"/> Family rules/respect/right from wrong</p> <p><input type="checkbox"/> Encourage expression of feelings</p> |
| <p>Family support and relationships</p> <p><input type="checkbox"/> Listen/respect/show interest in activities</p> <p><input type="checkbox"/> Eat meals as a family</p> <p><input type="checkbox"/> Substance abuse, domestic violence, depression</p> |
| <p>Community interaction</p> <p><input type="checkbox"/> Discuss community and recreational programs, school and after school care</p> <p><input type="checkbox"/> Volunteer and become involved with school</p> <p><input type="checkbox"/> Meet your child's school teachers</p> |
| <p>Physical activity</p> <p><input type="checkbox"/> Assess and counsel on ways to increase activity level</p> |

| | | |
|------|--------------|-----|
| 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 does what I ask them to do most of the time.
 - My child says positive things about himself/herself.
 - 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 |
| Shows 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. (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents) | | |
| 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: _____

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. Implemented 1997; Last redesign; December 2006.

Patient education:

Child: 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.
- Healthy eating is important. Talk with your child’s doctor about ways to improve healthy eating.
- Keep your child active. Talk to your child’s doctor about ways to increase activity levels.

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:
 - Praise your child every day
 - Be clear about behaviors that are okay or not okay
 - 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
safekids.org

Fire safety

Talk with firefighters at your local fire station

Poison prevention

Call the Poison Control Center
 800 222-1222