

PEDIATRIC VISIT 4 TO 5 YEARS

DATE OF SERVICE _____

NAME _____

M / F DATE OF BIRTH _____

AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ %

BMI _____ / _____ % TEMP _____

BP _____

HISTORY REVIEW/UPDATE: (note changes)

Medical history updated? Yes / No _____

Family health history updated? Yes / No _____

Reactions to immunizations? Yes / No _____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep:

Child care:

Recent changes in family: (circle all that apply)

New members, separation, chronic illness, death, recent move, loss of job, other _____

Environment: Smokers in home? Yes / No _____

Violence Assessment:

History of injuries, accidents? Yes / No _____

Evidence of neglect or abuse? Yes / No _____

RISK ASSESSMENT: CHOL TB LEAD

(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____

Counseling provided? Yes / No _____

Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex
<input type="checkbox"/>	<input type="checkbox"/>	Cover test/Eye muscles
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/ Gums/Dentition
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:

Typical diet: (specify foods): _____

Education: Choose from food guide pyramid 2hrs or less TV/day
Child can help prepare food for meals Mealtime can be fun
5 fruits/vegetables daily Food jags 1 or more hrs. physical activity

DEVELOPMENTAL SCREENING: (With Standardized Tool)

ASQ: PEDs Other: (specify) _____

Results: Wnl Areas of Concern: _____

Referred: Yes / No **Where?** _____

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Toilets alone Dresses self Plays in group
Separates from parent easily

Fine Motor: Copies: 0 _____ + _____ _____
Uses scissors Draws person, 3 parts

Language: Knows: What is:- spoon ; shoe ; door ;-made of?
Fluent sentences Recognizes 3-4 colors Defines 6-9 words: Ball
Lake Desk House Banana Curtain Ceiling Fence
Knows 2-3 opposites: fire is hot, ice is __ ; mom is woman, dad is __ ;
horse is big, mouse is __

Gross Motor: Balances on 1 foot for 10 seconds (2-3 times)
Hops Heel-toe walk Catches bounced ball

ANTICIPATORY GUIDANCE:

Social: School readiness Enrolled in Pre-K/K School avoidance
Management of aggression Promote self-help skills
Caution with strangers/animals

Parenting: Allow separation Promote initiative, creativity
Awareness of ADHD and learning disabilities

Play and communication: Monitor TV use Small chores
Creative, active and group play

Health: Dental care Fluoride if well water Bedwetting Fears
Nightmares Leg aches Normal sexual curiosity; simple answers
Masturbation Oedipal complex Use sunscreen
Tick prevention Second hand smoke

Injury prevention: Booster seat (up to 4'9") Ride in back seat
Riding toys in traffic environment Bicycle helmets Matches
Choking/suffocation Hot water 120° Water safety (tub, pool)
Poisoning (Plants, drugs, chemicals) Poison control #
Fall prevention (playground) Smoke detector/escape plan
Firearms (look alike toys, owner risk/safe storage)

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date _____
2. Review Lead and HCT results Refer for testing if none _____
3. PPD if positive risk assessment _____
4. Testing/counseling if positive cholesterol risk assessment _____
5. Dental visit advised or date of last visit _____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No (specify) _____

Signatures: _____