



Name: _____ DOB: _____ Actual Age: _____

Language Spoken _____ Interpreter Name _____

Date: _____

3 YEARS

NURSING INTAKE

Height:	Weight:	BMI:	BMI%:	BP:	Temp.:	Pulse:	Resp.:
Allergies:					Growth Charts Completed: []		
Abuse: Witness or Victim:					Notes:		
Alternate health care provider:					MA Signature:		

INTERVAL HISTORY

Diet:	Has WIC: Yes / No	Physical Activity:
Illnesses:		Stools:
Accidents:		Dental home:
Meds./Vits.:		Sleep Pattern:
		Seeing dentist: Yes / No
		Family history: HTN, heart disease, high cholesterol, DM, asthma
		Exposure to tobacco smoke:
		TB Risk: Yes / No

GROWTH-DEVELOPMENT: Physical Activity: _____

<input type="checkbox"/> Vocabulary of about 500 words	<input type="checkbox"/> Helps in dressing
<input type="checkbox"/> Goes up stairs alternating feet	<input type="checkbox"/> Copies +
<input type="checkbox"/> Plays with other children	<input type="checkbox"/> 20 teeth
<input type="checkbox"/> Knows age, sex, first, last name	<input type="checkbox"/> Cuts with scissors
<input type="checkbox"/> Balance on each foot, 1 second	

PARENTAL/PATIENT CONCERNS:

PHYSICAL EXAMINATION

General Appearance	<input type="checkbox"/> Well nourished and developed	Teeth	<input type="checkbox"/> Grossly normal, no cavities
	<input type="checkbox"/> No abuse/neglect evident	Heart	<input type="checkbox"/> No murmurs, regular rhythm
Head	<input type="checkbox"/> Symmetrical, A.F. closed	Lungs	<input type="checkbox"/> Breath sounds normal bilaterally
Eyes	<input type="checkbox"/> Conjunctivae, sclerae, pupils normal	Abdomen	<input type="checkbox"/> Soft, no masses, liver & spleen normal
	<input type="checkbox"/> Red reflexes present	Genitalia: Male	<input type="checkbox"/> Normal appearance, circ./uncirc.
	<input type="checkbox"/> Appears to see [] No strabismus		<input type="checkbox"/> Testes in scrotum
Ears	<input type="checkbox"/> Canals clear, TMS normal	Female	<input type="checkbox"/> No lesions, nl external appearances
	<input type="checkbox"/> Appears to hear	Hips	<input type="checkbox"/> Good abduction
Nose	<input type="checkbox"/> Passages patent	Femoral pulses	<input type="checkbox"/> Present and equal
Mouth & pharynx	<input type="checkbox"/> Normal color, no lesions, no cavities	Extremities	<input type="checkbox"/> No deformities, full ROM
Neck	<input type="checkbox"/> Supple, no masses palpated	Skin	<input type="checkbox"/> Clear, no significant lesions
		Neurologic	<input type="checkbox"/> Alert, moves extremities well

ASSESSMENT:

PLAN:

ORDERS: [] Vaccine reactions, risks and follow-up explained / VIS sheet given.

<input type="checkbox"/> HCT (if high risk)	<input type="checkbox"/> Immunizations (if not up to date)
<input type="checkbox"/> Vision screening yearly (objective)	<input type="checkbox"/> Immunization Registry
<input type="checkbox"/> Audiometry (subjective)	<input type="checkbox"/> Influenza vaccine (check recommendations)
<input type="checkbox"/> PPD	<input type="checkbox"/> Dental Referral given
<input type="checkbox"/> Rx for fluoride drops/chewable tabs .50/1.0 mg QD till age 14	<input type="checkbox"/> Lipid Profile (if high risk)
<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> Lead Blood Test (if not in chart)
<input type="checkbox"/> WIC Referral	

ANTICIPATORY GUIDANCE: Circle if discussed

Regular meals with snacks, caloric balance, sweets, sodium, iron, no bottles.
 Behavior: Fast moving, value judgments, very aware of peers Education on Fluoride varnish treatment
 Injury & Violence prevention: Toddler car seat, street dangers, knives, falls, drowning, caution with strangers, smoke detector, hot water temp., window guards, pool fence, play equipment, bike helmet, poison center phone number, storage of drugs, toxic chemicals, matches, and guns, emergency care plan, lead poisoning prevention
 Guidance: Role of father, B&B problems, stuttering, TV programs, regular exercise, brush teeth, dentist, UV skin protection, parent smoking, childcare plan, physical activity education, sun screen.

[] Refer to appropriate agency.

Next appointment [] 1 year or _____ Signature _____ Date _____