FLORIDA DEPARTMENT OF HEALTH

3 - 5 Year Child Health History & Physical Check-up

PLEASE PRINT

PERSONAL: ☐ **Well child visit** ☐ **Parent/Caregiver Request**

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP

CHILD INTERVAL HISTORY:

MEDICAL HISTORY (any changes or concerns since last visit) ☐ NO ☐ YES (DESCRIBE)

FAMILY MEDICAL HISTORY **(any changes or concerns since last visit)** ☐ NO ☐ YES (DESCRIBE)

ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS: ☐ NO ☐ YES (DESCRIBE)

DENTAL HISTORY/ ISSUES: ☐ NO ☐ YES (DESCRIBE)

DEVELOPMENTAL ISSUES: ☐ NO ☐ YES (DESCRIBE)

BEHAVIORAL ISSUES / ADHD Screening: ☐ NO ☐ YES (DESCRIBE)

CURRENT MEDS: ☐ VITAMINS ☐ IRON

DEVELOPMENTAL ASSESSMENT:

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (Does this client briefly balance on one foot, walk up the stairs with alternating feet, construct a block tower of more than 9 cubes, place small objects in a small opening, speaks in 3 to 4 word sentences, frequently asks questions, dress self, feeds self without difficulty by 3 yr.; Increased coordination, skipping, jumping, running and skating with good balance, tying own shoelaces, uses vocabulary of over 2100 words, identifies coins, names the primary colors, behaving more responsibly, by 5 yrs.)

☐ YES ☐ NO ☐ REFERRED Formalized Screening tool__________________ Results________________

NUTRITIONAL ASSESSMENT

☐ BREAST MILK ☐ WHOLE MILK ☐ TABLE FOODS ☐ FLUORIDE ☐ CUP ☐ BOTTLE ☐ FORMULA:_____________________

Is this a WIC participant? ☐ Yes ☐ No ☐ Referred

Is your home on: ☐ well water ☐ city water	Is city water fluoridated? ☐ YES NO ☐ DON'T KNOW	Age when weaned from breastfeeding:	Age when weaned from bottle:

What other beverages does this child drink? (check all that apply):

☐ Soy milk ☐ 2% reduced fat milk ☐ 1% low fat milk ☐ fat free milk ☐ tea ☐ Water with sugar

☐ Water ☐ Bottled Water ☐ 100% fruit juice ☐ Gatorade ☐ Fruit drinks ☐ soda

Nutrition supplements ____________________________________ ☐ other ______________________________

How often does the child eat these foods?

Meat, poultry, fish, beans, or eggs ☐ daily ☐ some days ☐ never

Milk, yogurt, or cheese ☐ daily ☐ some days ☐ never

Vegetables ☐ daily ☐ some days ☐ never

Fruits ☐ daily ☐ some days ☐ never

Grains – breads, cereal, rice, or pasta ☐ daily ☐ some days ☐ never

Cookies, cakes, pies, candy ☐ daily ☐ some days ☐ never

Fried foods, French fries, sausage, hot dogs, bacon ☐ daily ☐ some days ☐ never

Physical Activity:

Does your child engage in at least one hour per day of physical activity?

Running? ☐ Yes ☐ No, Jumping? ☐ Yes ☐ No, Dancing? ☐ Yes ☐ No Playing outside? ☐ Yes ☐ No

How many hours does your child spend TV watching? #________hours/ each day

How many hours does your child spend using the computer? #________hours/ each day

How many hours does your child spend playing video games? #________hours/ each day

LAB TESTS: ☐ **Previously Screened**

☐ LEAD RISK ASSESSMENT (@ 3.-6 yrs., if pos do blood test	☐ BLOOD LEAD TESTING (@ 12 & 24 mo; @ 36-72 mo, if not previously screened.)	☐ U/A (Protein____ Sugar____ WBC's____ (5 yrs & as indicate)	☐ TB SCREEN/PPD RESULTS________	☐ SICKLE CELL SCREENING	☐ OTHER (Specify, as indicated)

Signature/Title_____________________________ Date_________________

Signature/Title_____________________________ Date_________________

Label

DH 3105L, 09/08 (Replaces DH 3105A & DH 3105B)

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PHYSICAL EXAM

TEMP: PULSE: RESP: BLOOD PRESSURE: Type:	HEIGHT: Percentile:	WEIGHT: Percentile:	BMI **percentile for age**: (2 and up)

Check as appropriate √	**N**	**A**	**N=Normal A=Abnormal COMMENTS**
1. Appearance			
2. Skin			
3. Head			
4. Eyes			
5. Ears			
6. Nose			
7. Mouth/Throat			
8. Teeth/Gums			
9. Nodes			
10. Heart			
11. Lungs			
12. Abdomen/Umbilicus			
13. Femoral Pulse			
14. External Genitalia			
15. Hip Exam			
16. Extremities			
17. Spine			
18. Neurological			
19. Other			

SENSORY SCREEN:

VISION: ☐ NORMAL ☐ ABNORMAL ☐ REFERRED
With glasses: RIGHT 20/____ LEFT 20/____ BOTH 20/____.
Without glasses: RIGHT 20/____ LEFT 20/____ BOTH 20/____.

HEARING: ☐ NORMAL ☐ ABNORMAL
RIGHT ☐ PASSED ☐ FAILED ______db/________mHz ☐ REFERRED
LEFT ☐ PASSED ☐ FAILED ______db/________mHz ☐ REFERRED

DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? ☐ YES ☐ NO (Describe)

IMMUNIZATIONS PLAN: DUE TODAY________________________________ ☐ ADMINISTERED ☐ DEFERRED/PARENT DECLINED ☐ NONE DUE

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

☐ CAR/ BOOSTER SEAT	☐ SAFETY- HOME/ POOL/ FALLS	☐ SLEEPING	☐ DAYCARE	☐ TOILET TRAINING
☐ TEETHING	☐ FEVER EDUCATION	☐ DENTAL HYGIENE	☐ CUP, FINGER FOODS	☐ NO BOTTLE
☐ SOLID FOODS	☐ NUTRITION / SNACKS	☐ SELF FEEDING	☐ CHOKING, ASPIRATION	☐ READ TO CHILD
☐ PETS IN HOME	☐ SIBLING INTERACTION	☐ TANTRUMS	☐ TALK & NAME OBJECTS	☐ POISONS
☐ LEAD EXPOSURE	☐ DISCIPLINE/LIMITS & PRAISE	☐ 2ND HAND SMOKE	☐ CONTROL TV VIEWING	☐ SKIN/SUN PROTECTION
☐ DOMESTIC VIOLENCE	☐ SHAKEN BABY SYNDROME	☐ FIREARMS IN HOME	☐ POST PARTUM DEPRESSION	☐ DECREASED APPETITE

☐ OTHER ____________________________ ☐ LITERATURE GIVEN ____________________________

ASSESSMENT/DIAGNOSIS:

PLAN/ORDERS/REFERRAL:

RETURN APPT:

ORDERS REVIEWED BY:

Label

Signature/Title_______________________________ Date_________________

Signature/Title_______________________________ Date_________________

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