WELL CHILD 4 – 5 YEARS	Name: ☐ Female ☐ Male
Visit Date: ___/____/____	DOB: ____/____/____ Age: _____
Language: ☐ English Other:	☐ Interpreter used – Name:

BP:	T:	P:	RR:	Height: in.	Weight: lb.	BMI %:	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies: **Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ low fat milk **WIC:** ☐ Yes ☐ No

Foods: **Seeing dentist:** ☐ Yes ☐ No

Appetite: **TB risk:** ☐ No ☐ Yes

Significant weight ☐ loss ☐ gain lbs.

Activity/Exercise:

Elimination:

Sleep:

Illnesses:

Childcare:

PARENTAL CONCERNS

GROWTH and DEVELOPMENT

☐ Hops on one foot	☐ Dresses with minimal supervision
☐ Counts 4 objects	☐ Knows most letters, 4-5 colors
☐ Catches/throws a ball	☐ Knows name, address, phone #
☐ Knows opposites	☐ Plays well with other children

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet and Exercise	☐ regular balanced meals with healthy snacks ☐ appropriate weight ☐ physical activity
Safety	☐ bike helmet ☐ household safety ☐ water safety ☐ car seat/seat belt ☐ street dangers ☐ caution with strangers ☐ weapons ☐ sun screen
Guidance	☐ school readiness/plans ☐ TV/media monitoring ☐ basic sex education ☐ family dynamics ☐ household chores ☐ rules/consequences

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Heart**	☐ regular rhythm ☐ no murmur
		Femoral pulses	☐ normal bilaterally
Head	☐ symmetrical	**Abdomen**	☐ soft, no masses ☐ liver & spleen normal
Eyes	☐ red reflex present R L ☐ no strabismus ☐ vision grossly normal	**Genitalia**	☐ grossly normal
		male:	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal ☐ hearing grossly normal	**Spine**	☐ normal, no sacral dimple
		Extremities	☐ no deformities, full ROM
Nose/mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction
Teeth	☐ dentition WNL ☐ no cavities evident	**Skin**	☐ clear, no significant lesions
Neck	☐ supple / no masses	**Neurologic**	☐ normal tone ☐ normal DTR's
Lungs	☐ clear to auscultation bilaterally		

Comments:

VISION	**Near**	OD:	OS:	OU:
	Far	OD:	OS:	OU:
AUDIO - metry	**Right**	dB	Hz	☐ WNL
	Left	dB	Hz	☐ WNL

Performed by:

ASSESSMENT:

PLAN:

ORDERS: ☐ Vaccine reactions, risks and follow-up explained /VIS sheets given ☐ Immunization registry entry

Immunizations- ☐ DTaP ☐ IPV ☐ MMR ☐ Varicella *(4 years)* ☐ Influenza *(yearly)*

Fluoride - ☐ Rx. 0.5 mg qd ☐ Fluoride varnish ☐ **Vision screening** (yearly) ☐ **Audiometry** (@ 4 and 5 yrs) ☐ **PPD**

Labs: ☐ U/A @ 5 years ☐ Hgb. ☐ Lead blood test (if not in chart) Other:

REFERRAL: ☐ WIC Other: _____ ☐ PM 160 completed

Next appointment: ☐ 1 year Other: _____ **Provider Signature:** _____