VACCINES: P C

WELL CHILD 3 YEARS

Today's Date:_____

Patient Name:_____ Date of Birth:_____

FAMILY HISTORY:
Changes in household since last visit ___Yes/No Explain_____
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent ___ Other_____
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare___Other_____

NUTRITION:
1. Does your child have any recurrent problems with development, special diet, weight gain/loss, refusal of any food groups, stomach problems or anemia? ___Yes/No (circle any that apply, explain below)
   List: _____
2. Usual number of servings per day: 1,2,3, etc
   ___Dairy ___Fruits ___Vegetables
   ___Bread, cereal, rice and pasta
   ___Meat, poultry, fish, eggs and dry beans

CHILD HEALTH: Indicate Yes/No or Check ☑ any that apply.
1. Does your child have any food or drug allergies? ___ Yes/No List_____
2. Has your child had any major illness, surgeries, injuries or hospitalizations? _____Yes/No
   List:_____
3. Does your child have any physical problems? ____Yes/No ___Low Weight Gain ___Weight Loss ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other_____
4. Does your child take any medications regularly? _____Yes/No _____
5. Has your child seen a dentist or scheduled for a dental appointment? _____Yes/No

IMMUNIZATIONS: Check ☑ Yes or No
___**Yes** ___**NO** Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY: Indicate Yes or No
Vision Screen:
1. Does your child seem to see well? _____Yes/No
2. Do your child's eyes appear to cross, drift or seem lazy? ___Yes/No Explain_____
3. Do your child's eyes appear unusual? ___Yes/No Explain_____

Hearing Screen:
1. Does your child answer different kinds of questions (when, what, where)? _____Yes/No
2. Does your child notice different sounds (telephone ringing, shouting, doorbell)?____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Brushes teeth with help _____Yes/No
2. Builds tower of 6 cubes/blocks _____Yes/No
3. Uses Pronouns I, You, Me _____Yes/No
4. Throws ball over hand _____Yes/No

MENTAL HEALTH: Check ☑ any that apply.
Feelings: ___Appropriate for age ___Out of control ___Angry ___Sad ___ Fearful ___ Sullen ___Anxious
Social Interaction: ___Appropriate for age ___Withdrawn ___Clings excessively ___Communicates non-verbally
Thinking: ___Appropriate for age ___ Problems Concentrating ___Distracted ___Mistrustful ___Easily frustrated
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ____Yes/No
Explain: _____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check here ☐ if no problems are noted.
Skin: ___rashes ___infections
Eyes: ___Eye Discharge ___Deviation ___Poor vision ___Excessive blinking
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge ___Sore throat
Cardio: ___History of murmur
Respiratory: ___Trouble Breathing ___Wheezing
Gastrointestinal: ___Frequent Bowel Movements ____Vomiting
Genitourinary: ____Abnormal Appearance ___Discharge ___Burning with urination
Neuromuscular: ____Seizures ____uncoordinated movements ____gait
Musculoskeletal: ____Fractures ____Deformity

Form Complete:_____(staff initials)

WELL CHILD 3 YEARS

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Weight:_____ Height:_____ Pulse_____ Resp_____ Temp:_____ B/P_____

Audioscope Screening: Testing by _____ ___20 db ___25 db ___40 db

	500	1000	2000	4000
Right Ear				
Left Ear				

FOR OFFICE USE ONLY

PHYSICAL EXAM:	**Normal**	**Abnormal**	**Comments**
Appearance	_____	_____	_____
Head/fontanels	_____	_____	_____
Skin/nodes	_____	_____	_____
Eyes	_____	_____	VA: OD_____OS_____ Correction_____No correction____
Symmetric Corneal light reflex	_____	_____	_____
Conjugate gaze bilaterally	_____	_____	_____
Red Reflex present bilaterally	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth/Throat	_____	_____	_____
Teeth	_____	_____	_____
Neck	_____	_____	_____
Chest/breasts	_____	_____	_____
Heart/Pulses	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia/anus	_____	_____	_____
Spine/Hips	_____	_____	_____
Extremities	_____	_____	_____
Muscle Tone	_____	_____	_____
DTRs	_____	_____	_____

ASSESSMENT: **1.** Well Child 3 Years Old_____ **2.**_____

3. _____ **4.**_____

PLAN:

Immunizations: **Required:** ___Hep A # 1 ___PPD **Catch up vaccinations:** ___Hep B # 3 ___PCV # 4 ___Varicella

___Parent declines (List)_____

Lab: **Medicaid Catch up between 2 & 5 yrs:** ___**Lead** ___**Hct/Hgb** ___OtherLabs:_____

___Hep C (if 12 months old or older and born to HCV infected woman)_____

EPSDT Questionnaires/Screen: ___**Lead questionnaire given** ___**TB questionnaire given** **PEDS:** ☐**Pass** ☐**Fail**

Referral made to : _____

Dental: Parent advised to make Preventive Dental Appointment: _____

Health Education Handout Given to Parent/Guardian _____

RTC in: _____months/prn _____yr/prn

Document in Document1 1/24/06 9/23/09 12/6/2010 4/30/12