VACCINES: P C

WELL CHILD 5 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 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:
   ___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:
Vision Screen: **Indicate Yes or No**
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 seem to hear well? _____Yes/No
2. Does your child seem to increase the volume of the TV or radio? ____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Brushes teeth without help ______Yes/No
2. Copies _____Yes/No
3. Carries on a conversation _____Yes/No
4. Balances on 1 foot for 3 seconds _____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
Musculoskeletal: ____Fractures ____Deformity

Form Complete:______(staff initials)

WELL CHILD 5 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	________	________	________
Ears	________	________	________
Nose	________	________	________
Mouth/Throat	________	________	________
Teeth	________	________	________
Neck	________	________	________
Chest/breasts	________	________	________
Heart/Pulses	________	________	________
Lungs	________	________	________
Abdomen	________	________	________
Genitalia/anus	________	________	________
Spine/Hips	________	________	________
Extremities	________	________	________
Muscle Tone	________	________	________
DTRs	________	________	________

ASSESSMENT: 1. Well Child 5 Years________________________ __**2.**______________________________

3. ______________________________________ **4.**______________________________

PLAN: Immunizations: ___Vaccinations up to date

Required if not given: ___Hep A # 2 ___ DTaP # 5 ___IPV # 4 ___MMR # 2 ___PPD

Catch up vaccinations: ___Hep A # 1 ___Prevnar # 4 ___Varicella **High Risk:** ___Influenza

___Parent declines (List)____

Lab: **Catch up between 2 & 5 yrs: ___Lead ___Hct/Hgb** Other Labs:________________________

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

EPSDT Questionnaire: ___Lead questionnaire given ___TB questionnaire given

Referral made to : ____

Dental: Parent advised to make Preventive Dental Appointment: ______

Health Education Handout Given to Parent/Guardian _______

RTC in: __________months/prn _________yr/prn