VACCINES: P C

WELL CHILD 6 to 10 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 group, stomach problems or anemia? ___Yes/No (circle any that apply, explain below)
   List: ____
2. Usual number of servings per day: 1, 2, 3
   ___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: Answer Only if 6 Year Olds

1. Can Skip ____Yes/No
2. Writes first and last name ____Yes/No
3. Ties shoes ____Yes/No
4. Simple addition and subtraction ____Yes/No
5. Knows days of the week ____Yes/No

MENTAL HEALTH: Check ☑ any that apply. Check here ☐ if no problems are noted.

____Sleep Problems ___Behavior problems ___Relationship problems with parents, siblings, peers
___Problems in school ___Special Education classes ___No extracurricular activities
___Excessive extracurricular activities ___Substance abuse/use ___Self-Concept problems ___Body Image Problems

What is your child's grade level? __________

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 ___ uncontrolled bowel movements ___Vomiting ___Bed wetting
Genitourinary: ____Abnormal Appearance ___Burning with urination ___Penile/vaginal discharge
Neuromuscular: ____Seizures ____uncoordinated movements ____gait
Musculoskeletal: ____Fractures ___Sprains ___sports injury ____Deformity

Form Complete:______(staff initials)

WELL CHILD 6 to 10 YEARS

Today's Date:________________

Patient Name:________________________________ Date of Birth:________________

Vitals: 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 (Tanner stage)______		_______	______________________________
Heart/Pulses	_______	_______	______________________________
Lungs	_______	_______	______________________________
Abdomen	_______	_______	______________________________
Genitalia/anus(Tanner stage)______		_______	______________________________
Spine/Hips	_______	_______	______________________________
Extremities	_______	_______	______________________________
Muscle Tone	_______	_______	______________________________
DTRs	_______	_______	______________________________

ASSESSMENT: **1.** Well Child Exam____________________________ **2.**____

3. ____**4.**____

PLAN: Immunizations: ___Vaccinations up to date

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

Catch up vaccinations: ___Hep A # 1 ___Prevnar # 4 ___Varicella #2 **High Risk:** ___**Influenza**

___Parent declines vaccines(List)____

Lab: **Lab Work Required for Medicaid**: ___**Hct/Hgb (6 yr olds)**

___Lead Other Labs:____

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

EPSDT Questionnaires: ___ Lead questionnaire given **(6 yr old)** ___TB questionnaire given (6-10 y/o)

Referral made to :____

Dental: Parent advised to make Preventive Dental Appointment: ______

Health Education Handout Given to Parent/Guardian _______

RTC in: ___________months/prn __________yr/prn