





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

PLEASE PRINT

**PHYSICAL EXAM**

|       |        |       |                 |             |             |                                       |
|-------|--------|-------|-----------------|-------------|-------------|---------------------------------------|
| TEMP: | PULSE: | RESP: | BLOOD PRESSURE: | HEIGHT:     | WEIGHT:     | BMI percentile for age:<br>(2 and up) |
| Type: |        |       |                 | Percentile: | Percentile: |                                       |

| Check as appropriate <input type="checkbox"/> <input checked="" type="checkbox"/> | 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: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED<br>With glasses: RIGHT <u>20/</u> LEFT <u>20/</u> BOTH <u>20/</u><br>Without glasses: RIGHT <u>20/</u> LEFT <u>20/</u> BOTH <u>20/</u> | HEARING: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL<br>RIGHT <input type="checkbox"/> PASSED <input type="checkbox"/> FAILED _____db/ _____mHz <input type="checkbox"/> REFERRED<br>LEFT <input type="checkbox"/> PASSED <input type="checkbox"/> FAILED _____db/ _____mHz <input type="checkbox"/> REFERRED |
| DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO (Describe)  |   |
| <b>IMMUNIZATIONS PLAN:</b> DUE TODAY _____ <input type="checkbox"/> ADMINISTERED <input type="checkbox"/> DEFERRED/PARENT DECLINED <input type="checkbox"/> NONE DUE   |   |

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE:**

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

|                              |                              |
|------------------------------|------------------------------|
| <b>ASSESSMENT/DIAGNOSIS:</b> | <b>PLAN/ORDERS/REFERRAL:</b> |
|------------------------------|------------------------------|

|              |                     |
|--------------|---------------------|
| RETURN APPT: | ORDERS REVIEWED BY: |
|--------------|---------------------|

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

Label