



5 year up to 10 Year Child Health History & Physical Check-up

PLEASE PRINT

PERSONAL:

Well child visit Parent/Caregiver Request

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP
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CHILD INTERVAL HISTORY:

MEDICAL HISTORY (any changes or concerns since last visit) NO YES (DESCRIBE)

FAMILY MEDICAL HISTORY (any changes or concerns since last visit) NO YES (DESCRIBE)

ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS: NO YES (DESCRIBE)

DENTAL HISTORY/ ISSUES: NO YES (DESCRIBE)

DEVELOPMENTAL ISSUES: NO YES (DESCRIBE)

BEHAVIORAL ISSUES / ADHD Screening: NO YES (DESCRIBE)

CURRENT MEDS: VITAMINS IRON

NUTRITIONAL ASSESSMENT

Is your home on: well water city water Is city water fluoridated? YES NO DON'T KNOW Do you receive Fluoride: YES NO DON'T KNOW

Does this client have ANY concerns about their health or diet? NO YES, explain: _____

Check all this client has had in the last 30 days: Vomiting Diarrhea Constipation Nausea Dental problems

Difficulty chewing or swallowing Food Allergy or problem _____

Special diet _____

Health or medical problem _____

What other beverages does this child drink? (check all that apply):

Soy milk Whole milk 2% reduced fat milk 1% low fat milk fat free milk tea Water with sugar

Water Bottled Water 100% fruit juice Gatorade Fruit drinks soda

Nutrition supplements _____ other _____

How often does the child eat these foods?

Meat, poultry, fish, beans, or eggs <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Milk, yogurt, or cheese <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Vegetables <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never
Fruits <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Grains – breads, cereal, rice, or pasta <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Cookies, cakes, pies, candy <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never
Fried foods, French fries, sausage, hot dogs, bacon <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never		

Physical Activity:

Does your child engage in at least one hour per day of physical activity?

Running? Yes No, Jumping? Yes No, Dancing? Yes No Playing outside? Yes No

How many hours does your child spend TV watching? # _____ hours/ each day

How many hours does your child spend using the computer? # _____ hours/ each day

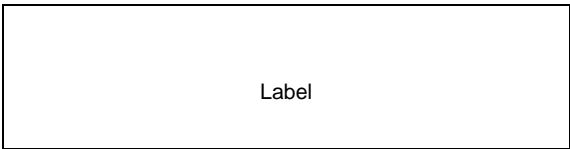
How many hours does your child spend playing video games? # _____ hours/ each day

LAB TESTS: Previously Screened

<input type="checkbox"/> BLOOD LEAD TESTING (@ 3-6 years, if not previously screened.)	<input type="checkbox"/> U/A (Protein _____ Sugar _____ WBC's _____ (5 yrs & as indicate)	<input type="checkbox"/> SICKLE CELL SCREENING
<input type="checkbox"/> Hgb/Hct _____ (adolescent females as indicated)	<input type="checkbox"/> TB SCREEN / PPD RESULTS _____	<input type="checkbox"/> OTHER (Specify, as indicated)

Signature/Title _____ Date _____

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PHYSICAL EXAM

TEMP:	PULSE:	RESP:	BLOOD PRESSURE:	HEIGHT:	WEIGHT:	BMI percentile for age: (2 and up)
Type:	LMP:	LNMP		Percentile:	Percentile:	

Check as appropriate <input checked="" type="checkbox"/>	N	A	N=Normal A=Abnormal	COMMENTS
1. Appearance				Tanner Staging
2. Skin				
3. Head				
4. Eyes				
5. Ears				
6. Auditory Acuity (Rt. & Lt.)				
7. Nose				
8. Mouth/Throat				
9. Teeth/Gums				
10. Nodes				
11. Heart				
12. Lungs				
13. Abdomen/Umbilicus				
14. Femoral Pulse				
15. External Genitalia				
16. Extremities				
17. Spine				
18. Neurological				
19. Other				

SENSORY SCREEN:

VISION: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED With glasses: RIGHT <u>20/</u> LEFT <u>20/</u> BOTH <u>20/</u> Without glasses: RIGHT <u>20/</u> LEFT <u>20/</u> BOTH <u>20/</u>	HEARING: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL RIGHT <input type="checkbox"/> PASSED <input type="checkbox"/> FAILED _____ db/ _____ mHz <input type="checkbox"/> REFERRED 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)	
IMMUNIZATIONS PLAN: DUE TODAY _____ <input type="checkbox"/> ADMINISTERED <input type="checkbox"/> DEFERRED/PARENT DECLINED <input type="checkbox"/> NONE DUE	

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> NUTRITION / SNACKS	<input type="checkbox"/> FEVER EDUCATION	<input type="checkbox"/> DECREASED APPETITE	<input type="checkbox"/> TANTRUMS	<input type="checkbox"/> POISONS
<input type="checkbox"/> PRESCHOOL	<input type="checkbox"/> DISCIPLINE/ LIMIT SETTING	<input type="checkbox"/> CONTROL TV VIEWING	<input type="checkbox"/> LEAD EXPOSURE	<input type="checkbox"/> COMMUNICATION	<input type="checkbox"/> SLEEPING
<input type="checkbox"/> READ TO CHILD	<input type="checkbox"/> NO PLAYING WITH MATCHES	<input type="checkbox"/> PETS IN HOME	<input type="checkbox"/> FIREARMS IN HOME	<input type="checkbox"/> SAFETY: WATER, SKATEBOARD, BIKES, STREETS	
<input type="checkbox"/> SEXUAL CURIOSITY	<input type="checkbox"/> SIBLING INTERACTION	<input type="checkbox"/> PEER RELATIONS	<input type="checkbox"/> SCHOOL PERFORMANCE	<input type="checkbox"/> SEAT BELTS /BOOSTER SEAT	
<input type="checkbox"/> 2 ND HAND SMOKE	<input type="checkbox"/> REGULAR PHYSICAL ACTIVITY	<input type="checkbox"/> PARENTAL ROLE MODEL	<input type="checkbox"/> DOMESTIC VIOLENCE	<input type="checkbox"/> SKIN CARE /SUN PROTECTION	
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> LITERATURE GIVEN _____				

ASSESSMENT/DIAGNOSIS:	PLAN/ORDERS/REFERRAL:
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RETURN APPT:	ORDERS REVIEWED BY:
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Signature/Title _____ Date _____

Signature/Title _____ Date _____

Label