

3-5 Years

Department of State Health Services Child Health Record Preventive Health Visit

Family Profile and Health

No change in household since last visit
Child lives with:
 Mother Father Stepparent Grandparent
 Other
 Total adults living in home: _____
 Total children living in home: _____
 Primary caretaker for this child: _____
 Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:
 Developmental Screening: P F
Type of Developmental Screen:
 Standardized Parent Questionnaire: _____
 Standardized Observational Screen: _____
 Other: _____
 Further assessment needed: Y N
Mental Health (see "Key Elements" on reverse side):

Child's Health/Interim History

Allergies:
 Does the system review note any problems
 or parent concerns: Y N
 Explain:
 Major illness, injury, hospitalization, surgery (since last visit):
 Medications taken regularly – Type/Reason:

Dental Care:

Physical Examination

Temp _____	Pulse _____	BMI _____
BP _____	Height _____	Resp _____
(%) _____	(%) _____	Weight _____
(%) _____	(%) _____	(%) _____

N <input type="checkbox"/> A <input type="checkbox"/> NE <input type="checkbox"/>	N <input type="checkbox"/> A <input type="checkbox"/> NE <input type="checkbox"/>
____ Appearance	____ Heart/pulses
____ Head/fontanels	____ Lungs
____ Skin/nodes	____ Abdomen
____ Eyes	____ Genitalia/anus
____ Ears	____ Spine
____ Nose	____ Extremities
____ Mouth/throat	Neurologic:
____ Teeth	____ Muscle tone
____ Neck	____ DTRs
____ Chest/breasts	

Additional documentation:

Client Information

Name: _____
 DOB: _____ / _____ / _____ Age: _____ Sex: _____
 SSN/Record No.: _____
 Race/Ethnicity: _____
 Informant/Relationship: _____
 Medical Home: _____

Nutrition

Problems: special diet, inappropriate weight gain, anemic,
 lead poisoning, chronic GI problems, major food allergies,
 refusal of any food group, developmental* Y N
**If answered yes, further assessment needed.*
 Usual Servings Per Day:
 _____ Dairy _____ Vegetables _____ WIC: Y N
 _____ Breads, cereal, rice, and pasta _____ Flouride Supplements: Y N
 _____ Meat, poultry, fish, eggs, and dry beans
 _____ Fruits _____ Vitamins: Y N

Sensory

Vision Screen: Normal Abnormal
Hearing Screen: Normal Abnormal
Hearing Screen Used (3 years) : _____ Hearing Checklist for Parents

Health Education

Injury Prevention	<input type="checkbox"/> Toilet training
<input type="checkbox"/> Car safety restraints	<input type="checkbox"/> Social interaction
<input type="checkbox"/> Poisoning	<input type="checkbox"/> School readiness
<input type="checkbox"/> Fire safety	<input type="checkbox"/> Sex education
<input type="checkbox"/> Firearms	Health Promotion
<input type="checkbox"/> Street, water, bicycle safety	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Scissors/sharp objects	<input type="checkbox"/> Well-child care
<input type="checkbox"/> Stranger safety	<input type="checkbox"/> Dental care, appointment
<input type="checkbox"/> Teach telephone no. & address	<input type="checkbox"/> Family planning
<input type="checkbox"/> Self-safety	<input type="checkbox"/> Daycare
<input type="checkbox"/> Passive smoking	Nutrition
Behavior	<input type="checkbox"/> Healthy diet/snacks
<input type="checkbox"/> Talk/read with child	<input type="checkbox"/> Junk food
<input type="checkbox"/> Exploration	<input type="checkbox"/> Iron-rich foods
<input type="checkbox"/> Limit television	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Discipline, consistency	

Assessment

Plan

TB Risk Screening Tool: _____
 Dental referral made: Y N
WIC: Referred Refused N/A
Immunizations: Up to date To be given today Deferred
Explain:
Lab: Lead questionnaire: Y N
 Hct/Hgb _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title: _____

3-5 Years

If used for documentation: _____

Patient's Name: _____

Date: _____

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Cardio/respiratory: History of murmur, trouble with breathing, wheezing

Gastrointestinal: Bowel movement frequency, soiling

Genitourinary: Dysuria, discharge

Neuromuscular: Seizures, coordination, gait

Musculoskeletal: Fractures

Eyes: Eye discharge, blinking, tearing

Nose/Mouth/Throat/Teeth: Nasal congestion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Out of control, angry, sad, fearful, sullen, anxious

Behavior: Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, self-abuses

Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally

Thinking: Mistrustful, distracted, easily frustrated

Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems

Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes
