

DATE _____

PATIENT NAME	DOB	SEX	PARENT NAME
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Allergies	Current Medications
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Prenatal/Family History

Weight	Percentile	Height	Percentile	BMI	BP	Temp.	Pulse	Resp.
	%		%					

Interval History:
(include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

Grains _____ servings per day

Vegetables _____ servings per day

Fruits _____ servings per day

Milk _____ servings per day

Meat/Beans _____ servings per day

City water Well water Bottled water

Elimination

Normal Abnormal

Sleep

Normal (8 – 12 hours) Abnormal

Abnormal Findings and Comments
If yes, see additional note area on next page

WIC Y N

Screening:

Hearing

Screening audiometry (optional)

Responds to noisemaker (optional)

Parental observation/concerns

Vision

Can see small objects

Ocular alignment

Visual acuity

_____ R _____ L _____ Both

Parental observation/concerns

Procedures

If Risk:

IPPD _____ (result)

Hct or Hgb _____ (result)

Cholesterol _____ (result)

If not previously tested:

Lead level _____ mcg/dl (required for Medicaid)

Immunizations:

Immunizations Reviewed, Given & Charted – *if not given, document rationale*

MCIR checked/updated

Patient Unclothed Y N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Abnormal Findings and Comments
If yes, see additional note area on next page

Results of visit discussed with parent Y N

Plan

History/Problem List/Meds Updated

Referrals

WIC Head Start

Children Special Health Care Needs

Transportation

Other _____

Other _____

Anticipatory Guidance/Health Education
(✓ if discussed)

Healthy and Safe Habits

Teach child to wash hands, wipe nose w/tissue

Limit TV, watch programs together

Reinforce bedtime routine

Injury and Illness Prevention

Fires/Burns/test smoke alarms

Appropriate car seat placed in back seat

Pool/tub/water safety

Use bike helmet

Teach stranger safety

Childproof home - (matches, guns, medicines)

Supervise play, ensure playground safety

Teach pedestrian safety

Nutrition

Limit sweets

Serve low-fat dairy products

Offer variety of healthy foods, let child decide

Oral Health

Schedule dental appointment

Teach child to brush teeth

Sexual Development and Education

Expect normal curiosity

Explain certain body parts are private

Social Competence

Reinforce limits, provide choices

Encourage talking and reading

Encourage safe exploration

Praise good behavior and accomplishments

Help child cope with fears

Family Support and Relationships

Show affection, spend time with each child

Create family time together

Substance Abuse/ Domestic Violence

Handle anger constructively, help siblings resolve conflicts

Choose responsible caregivers

Community Interaction

Discuss community programs, preschool, head start, parenting groups

Next Well Check: 4 years of age	Provider Signature: _____
Developmental Questions and Observations on Page 2	

WELL CHILD EXAM-EARLY CHILDHOOD: 3 Years

DATE	PATIENT NAME	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the child:

Yes No

 Please tell me any concerns about the way your child is behaving or developing

 My child is able to play by him/herself for short periods of time.

 My child is able to leave me when in a known place.

 My child can tell when others are happy, mad or sad.

 My child copies a circle and a cross.

 My child eats a variety of foods.

 My child knows his/her name, age and sex.

 My child can jump off a step with both feet.

Ask the parent to respond to the following statements:

Yes No

 I have people who assist me when I have questions or need help.

 I am enjoying my time with my child.

 I have time for myself, partner and friends.

 I feel safe with my partner.

 I feel confident in parenting.

Provider to follow up as necessary

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Child Development			Parent Development		
Dresses self	Yes	No	Appropriately disciplines child	Yes	No
Rides a tricycle	Yes	No	Parent is loving toward Child.	Yes	No
My family understands my child's speech.	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Shows little or no preference for parent or caregiver	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Seeks comfort from parent when upset	Yes	No			

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

Your Child's Health at 3 Years

Milestones

Ways your Child is developing between 3 and 4 years of age.

Can sing a song.

Learning to share.

Talks about what he/she did during the day.

Can hop, jump on one foot.

Rides a tricycle or a bicycle with training wheels.

Knows his/her first and last name.

Begins to test limits.

Shows a silly sense of humor.

Throws a ball overhand.

Tries to draw a person with 3 parts (such as head, body, legs).

Knows what is real and what is pretend.

Builds towers of 9-10 blocks.

For Help or More Information:

Safe Gun Storage Information:

Call 1-202-662-0600 or go to www.safekids.org.

Car and Booster Seat Questions:

Contact the Auto Safety Hotline at 1-888-327-4236.

For information about lead screening:

Contact the Michigan Department of Community Health Hotline at 1-800-648-6942.

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222.

For information about childhood development:

Contact Michigan Head Start Association at 1-517-374-6472.

Parenting skills or support:

Call the Parents Hotline at 1-800-942-4357 or the Family Support Network of Michigan at 1-800-359-3722.

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233).

Health Tips:

Your child still needs about two cups of milk every day. Offer a variety of fruits and vegetables daily. Water is a healthy drink so offer it instead of sweetened drinks.

Help your child brush his/her teeth every day with a pea-sized amount of fluoride toothpaste. Make sure your child gets a dental checkup once a year.

Teach your child to wash their hands well after playing and using the toilet, and before eating. Use soap and rub hands together for about 20 seconds

Each child develops in his or her own way, but you know your child best. If you think he/she is not developing well, you can get a free screening. Call your child's doctor or nurse if you have questions.

Parenting Tips:

Children learn best by doing. They need to:

- Play active games (tag, ball, riding wheeled toys, climbing).
- Play imagination games (using dolls, figure toys, story books).
- Play with toys that use their hands (blocks, big puzzles).
- Limit television and computer time to less than one hour a day.

Help your child feel good about himself and others:

- Praise your child every day.
- Encourage your child's new friendships.
- Be consistent and clear about your child's behaviors that are okay or not okay.
- Use discipline to teach and protect your child, not to punish her or make her feel bad about herself.
- Help your child "use his words" when having a disagreement instead of hitting, kicking, biting or saying mean things.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Put your child in a safe place and walk away.
2. Call a friend or your partner. It can help to talk about what you are feeling.
3. Call the free Parent Helpline at 1 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

Safety Tips

Check your home for dangers often. Your child is not old enough to stay away from things that could harm him/her, like matches, guns, and poisons. Lock them up!

Continue using a car seat until your child weighs 40 pounds. After that, use a booster seat up to about 80 pounds. Keep your child in the back seat.

Make sure your child uses a helmet whenever he/she rides a tricycle, scooter, or other toys with wheels.