

PATIENT NAME		DOB	SEX	PARENT NAME		
Allergies			Current Medications			
Prenatal/Family History						
Weight	Percentile	Length	Percentile	BMI	BP	Temp.
	%		%			

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

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**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)  
 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 child/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

**Injury and Illness Prevention**

Appropriate car seat placed in back seat  
 Smoke-free Home and car /smoke alarms  
 Poison Control  
 Use bike helmet  
 Teach stranger/pedestrian/playground safety  
 Childproof home - (matches, poisons, guns, cigarettes, cords, cleaners, medicines, knives)  
 Gun safety

**Nutrition**

Limit sweets and soda  
 Serve low-fat foods

**Oral Health**

Schedule dental appointment  
 Teach child to brush teeth

**Sexual Development and Education**

Use correct terms, answer questions simply  
 Explain good touch/bad touch and that certain body parts are private

**Social Competence**

Reinforce limits, provide choices  
 Encourage child to talk about feelings  
 Continue to read and sing with your child  
 Simple household tasks & responsibilities  
 Praise good behavior and accomplishments

**Family Support and Relationships**

Listen/respect/show interest in activities  
 Eat meals as a family  
 Substance Abuse, Domestic Violence, Depression

**Community Interaction**

Discuss community programs, preschool, head start, parenting groups, after school child care

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**Next Well Check: 5 years of age**

**Developmental Questions and Observations on Page 2**

Provider Signature: \_\_\_\_\_

## WELL CHILD EXAM-EARLY CHILDHOOD: 4 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 learning how to play and share with others.

           My child says positive things about themselves.

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

           My child enjoys pretend play.

           My child eats a variety of foods.

           My child can sing a song.

           My child can hop on one foot.

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
Balances on each foot for 2 seconds	Yes	No	Parent is loving toward child	Yes	No
Says first and last name when asked	Yes	No	Positively talks, listens, and responds to child.	Yes	No
Copies a circle	Yes	No	Parent uses words to tell child what is coming next	Yes	No
Aggressive or destructive behavior that threatens, harms or damages people, animals or property	Yes	No			
Displays negativity, low self-esteem, or extreme dependence	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:**

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Staff Signature: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

## Your Child's Health at 4 Years

### Milestones

*Ways your Child is developing between 4 and 5 years of age.*

Counts on fingers and knows some letters.

Talks about what will happen tomorrow and what happened yesterday.

May begin to skip.

May have special friends and may tease or ignore some children.

Begins to know the difference between right and wrong and telling the truth and lying.

May want to be "just like you" and may want to share in the things you do.

Uses words to solve simple problems and say what they're feeling.

Plays dress-up and make believe with other children.

### For Help or More Information:

#### **Safety information:**

Call 1-202-662-0600 or go to [www.usa.safekids.org](http://www.usa.safekids.org)

#### **Car and Booster Seat Questions:**

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

#### **Poison Prevention:**

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

#### **For information about child development:**

Contact the Michigan Head Start Associations at 1-517-374-6472 online at [www.mhsa.ws](http://www.mhsa.ws)

#### **For information and programs on young children and parenting:**

- Call the Parents Hotline at 1-800-942-4357 or the Family Support Network of Michigan at 1-800-359-3722.
- Call your Intermediate School District Great Parents, Great Start for information on parenting support programs in your area. [www.mi.gov/greatstart](http://www.mi.gov/greatstart)

#### **Domestic Violence hotline:**

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

#### **For help teaching your child about fire safety:**

Talk with firefighters at your local fire station

### Health Tips:

Your child will need some "shots" before starting school. Make sure you get them soon.

Offer your child at least five small servings of fruits and vegetables every day. They are very healthy foods and make good snacks. Offer water instead of sweetened drinks.

Help your child get enough sleep so they will be happier and will learn easier! Put him/her to bed early so they get 10 to 12 hours of sleep at night. Have a bedtime routine to calm your child before going to sleep. Read a story or talk together before bed.

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:

Help your child know what to expect by making a calendar of pictures to show their activities for the day.

Children learn best by doing. They need to:

- Play active games (tag, ball, riding toys, climbing).
- Play board games and do 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.
- Be clear about behaviors that are okay or not okay.
- Help your child use words when they are feeling upset instead of hitting, kicking, biting or saying mean things.
- Talk to your child about why teasing other children is wrong and what he should do instead.

If you feel very mad or frustrated with your child:

1. Make sure your child is in a safe place and walk away.
2. Call a friend 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.

### Safety Tips

Booster car seats are for big kids! Use a booster in the back seat with lap/shoulder belts.

Make sure your child knows their address and phone number. Teach them how to call 911 in an emergency and to stay on the line if they have to call for help. Practice with a toy phone.

Teach your child to stop, drop, and roll on the ground if their clothes catch on fire.