3 Year Well Exam

meridianhealth
A WellCare Company

Date_____ Patient #_____

Name_____ Date of Birth_____

Address_____

_____

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver

☐ Others (including siblings)_____

_____

May release information to (parent, guardian, other family - list):

_____

_____

Parental concerns: _____

_____

Changes in child's health since last visit:_____

_____

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

- ☐ All caregivers consistent in discipline - show respect, reinforce limits
- ☐ Encourage family activity and involve children in choices
- ☐ Show affection; teach expression and handling of feelings
- ☐ Don't allow aggressive behavior
- ☐ Teach sharing and taking turns

BEHAVIOR:

- ☐ Play opportunities outside of home; discuss child's experiences
- ☐ Read wherever you go, not just books (signs, etc); let child tell part of stories
- ☐ Encourage child's questions and give simple direct answers
- ☐ Expect and encourage fantasy play and interactive games
- ☐ Limit screen time to 1 hour/day. Monitor, discuss inappropriate behaviors even in cartoons. No TV or DVD in bedroom
- ☐ Expect normal curiosity with genitals. Use correct terms and answer questions. Explain certain body parts are private
- ☐ Discuss community programs, preschool, Head Start

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Offer variety of healthy foods, low-fat dairy products
- ☐ Avoid junk food, no soda
- ☐ Daily family meals are important
- ☐ Assist in brushing teeth twice daily until 7-8 years old
- ☐ Dental visits twice yearly

SAFETY:

- ☐ Safety seat or booster with 5-pt harness until 40 lbs. In back seat until 12 years
- ☐ Child Safety Seat Inspection Center: seatcheck.org or 866-732-8243
- ☐ Constant supervision; including near playgrounds, windows, water, pets, driveways, strangers and streets
- ☐ Review guns, fire/CO safety
- ☐ If smoking in home: discuss quitting, limiting exposure

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care: _____

FAMILY RISK FACTORS

Changes in family since last visit:_____

_____

STRESS:

How much stress are you and your family under now?

☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?

☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other_____

How stressful is caring for your child?

☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless?

☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?

☐ No ☐ Sometimes ☐ **Often**

GENERAL HEALTH

Nutrition/Dental

YES	NO	
☐	☐	Bottle or pacifier? _____times/day
☐	☐	Cow's milk _____oz/day
☐	☐	Juice _____oz/day
☐	☐	Eats all food groups daily, including fruits & veggies?
☐	☐	**Daily oral health care**
☐	☐	**Has had yearly dental visit**

Elimination: ☐ Stooling: soft, easy to pass BMs_____

Sleep:_____hours through the night

YES	NO	
☐	☐	Problems? Night feedings?_____

DEVELOPMENT (Screen or refer if concerns or "No" response on milestones in **bold type**)

YES	NO	
☐	☐	**Plays with other children (not just next to)***
☐	☐	**Imaginative or pretend play***
☐	☐	**Helps with dressing, washes hands**
☐	☐	**Uses 2-4 word sentences***
☐	☐	**Speech 75% understandable** (*autism risk)
☐	☐	**Names animal pictures**
☐	☐	**May imitate vertical line or copy circle**
☐	☐	**Throws ball over head**
☐	☐	**Jumps with both feet**
☐	☐	May pedal tricycle if available

Family concerns about behavior, speech, learning, social or motor skills:

_____

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MEDICAL HISTORY

Name _____ Date of Birth _____

Allergies _____ Medications _____

Major medical illnesses/special healthcare needs _____

Hospitalizations/Surgeries _____

PHYSICAL EXAMINATION (UNCLOTHED)

Vital Signs: P:_____R:_____T:_____BP:_____ /_____ Weight _____ (_____%) Height _____(_____%)

BMI _____(_____%) Vision Screening R 20/_____ L 20/_____ Hearing: Assess risk

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	
☐	☐	☐	☐	Behavior/interaction with family	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Teeth	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	

Results reviewed (outside info, lab, etc.) _____

Impression _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent ☐ UTD ☐ Missed previous well visit, being caught up

Past adverse reaction to immunizations: ☐ No ☐ Yes _____

☐ Vaccines given ☐ Vaccines refused _____

Lab (if indicated) _____

☐ **Fluoride varnish given**

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) _____

Handouts _____

Return appointment _____

Signature _____ Date _____