4 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:

- ☐ Limit screen time, < 2 hours per day. Monitor programming
- ☐ No TV or DVD in bedroom
- ☐ Family physical and educational activities - museums, zoos, community projects
- ☐ Structure quiet bed time routine. Read or tell stories

BEHAVIOR:

- ☐ Discuss feelings and experiences, praise when sensitive to others' feelings
- ☐ Observe child's interaction with peers, offer suggestions and model appropriate actions
- ☐ Encourage and ask questions - respond with short, simple, factual answers
- ☐ Set appropriate limits, praise good behavior and accomplishments
- ☐ Assign simple chores (picking up toys, setting table)
- ☐ Structured learning/play opportunities - preschool, playgroups, Sunday school, etc.
- ☐ Teach child correct terms regarding bodies, explain privacy, discuss "rules" of behavior

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ 5+ fruits and vegetables, 3+ low-fat milk/dairy, limit junk food, NO soft drinks
- ☐ Model good eating habits. Family meal
- ☐ Brush teeth twice daily with fluoride toothpaste. Have family dental home

SAFETY:

- ☐ Teach safety with adults - no adult should tell child to keep secrets from parents, express interest in private parts, ask child for help with private parts
- ☐ Review matches, lighters, guns
- ☐ Teach pet, neighborhood, street, stranger safety, but **supervise** all activity near streets and driveways
- ☐ Swimming lessons don't guarantee safety, keep within arm's length
- ☐ 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	
☐	☐	Pacifier or thumb? _______
☐	☐	Cow's milk ________oz/day
☐	☐	Juice ________oz/day
☐	☐	Eats all food groups daily, including fruits & veggies?
☐	☐	**Twice daily brushing of teeth**
☐	☐	**Has had twice yearly dental visit**

Elimination: ☐ Stooling: soft, easy to pass BMs________

Sleep:_____hours through the night

YES	NO	
☐	☐	Problems? Eat during the night? ____________________

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

YES	NO	
☐	☐	**Family reports that child can do what most 4-year-olds can do**
☐	☐	**Plays games with other children***
☐	☐	**Dresses self with help**
☐	☐	**Speaks in sentences***
☐	☐	**Speech is understandable to strangers**
☐	☐	**Understands "on," "under," "big," "little"**
☐	☐	**Copies a circle**
☐	☐	**Balances on each foot for 2 seconds**

(*autism risk)

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: R______ L ______

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

Past adverse reaction to immunizations: ☐ No ☐ Yes ______________________

☐ Vaccines given ☐ Vaccines refused ______________________

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

Lab (if indicated) ______________________

Medical referral (if indicated) ______________________

Handouts ______________________

Return appointment ______________________

Signature ______________________ Date ______________________

Revised June 2012