# 5 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:

- ☐ Promote physical activity, limit screen time < 2 hours, monitor content
- ☐ Show affection in the family and model respect for all people
- ☐ Discuss anger and anger management and praise efforts for self-control
- ☐ Family meals, maintain bedtime routine, including reading
- ☐ Have family rules, chores. Praise for accomplishments, establish consequences for not following rules

BEHAVIOR:

- ☐ Talk about new experiences, friends, activities
- ☐ Visit school and playground, meet teacher. After-school care?
- ☐ Discuss possibility of bullying or kids being "mean"

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Ensure good breakfast at home or at school
- ☐ Balanced diet, healthy choices for snacks
- ☐ Observe good hygiene, hand-washing
- ☐ Supervise brushing, help with flossing
- ☐ Dental exams every 6 months

SAFETY:

- ☐ Not yet ready to monitor own street crossing or safety
- ☐ School bus safety and rules
- ☐ All wheeled activity requires wearing well-fitting helmet: biking, skating, using scooters
- ☐ Booster seat in back seat
- ☐ Teach home and emergency phone numbers, home address, home fire escape plan
- ☐ Teach safety with adults - **NO** adult should:
  - tell child to keep secrets from parents
  - express an interest in private parts
  - ask child for help with private parts
- ☐ 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 5-year-olds can do** |
| ☐ | ☐ | **Dresses self** |
| ☐ | ☐ | **Communicates easily with others, able to tell a story** |
| ☐ | ☐ | **Able to follow directions** |
| ☐ | ☐ | **Knows 4 or more colors** |
| ☐ | ☐ | May know some letters and numbers |
| ☐ | ☐ | **Draws a person with 3-6 body parts** |
| ☐ | ☐ | **Balances on each foot for 4 seconds, hops** |

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 health care 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 _____