6 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:

- ☐ Family fitness; limit screen time < 2 hours, monitor content
- ☐ Show affection in the family and model respect for all people
- ☐ Discuss anger management and praise efforts for self-control
- ☐ Family meals, maintain bedtime routine, including reading
- ☐ Family rules, chores. Praise accomplishments

BEHAVIOR:

- ☐ **School:** talk about new experiences, friends, activities, possibility of bullying or kids being "mean"
- ☐ Visit school and playground, meet teacher. After-school care?
- ☐ Clearly state expectations and consequences - no threats, but consistently follow through with consequences
- ☐ Encourage child to make choices. Listen to child respectfully - will help in developing autonomy, independence
- ☐ Answer child's questions about sex, drugs in a straightforward manner with as much or as little info as child needs

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Ensure good breakfast at home or at school
- ☐ Balanced diet - fruits/vegetables, whole grains, healthy snacks
- ☐ Observe brushing, help floss. Dental exams every 6 months

SAFETY:

- ☐ School bus safety and rules
- ☐ **All** wheeled activity requires wearing well-fitting helmet
- ☐ Booster seat in back seat until ~4'9" tall, shoulder strap across shoulder, not neck, can bend at knees while sitting against seat back
- ☐ 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	
☐	☐	3 servings of milk?
☐	☐	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? _____

DEVELOPMENT

School

Grade:_____

Favorite subject or activity:_____

Problems? ☐ Yes ☐ No _____

YES	NO	
☐	☐	Early reading
☐	☐	Able to print numbers to 10, write name, know L/R
☐	☐	Ties shoes
☐	☐	Rides bike
☐	☐	Following directions, begins to impose and follow rules

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

_____

Activities outside of school:_____

Peer relations: ☐ Good ☐ OK ☐ Poor

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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	
				Sexual maturity stage _____breast (female) _____genitals (male) _____pubic hair (female & male)	
☐	☐	☐	☐	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 _____

Lab (if indicated) _____

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

Medical referral (if indicated) _____

Handouts _____

Return appointment _____

Signature _____ Date _____