7-8 Year Well Exam

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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 outings, family meal, positive interactions, individual undivided attention
- ☐ Media limitation, monitor content - help become "media literate" by watching with children and commenting on messages
- ☐ Household chores, responsibilities for all

BEHAVIOR:
- ☐ Discuss school, activities, interests, friends. Any bullying?
- ☐ Talk about feelings, worries
- ☐ Encourage competence/independence
- ☐ Answer child's questions about sex, drugs simply with as much or as little info as child needs

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:
- ☐ Ensure healthy breakfast (3 meals per day), healthy snacks
- ☐ No soda; < 6 oz juice, > 2 cups skim milk (or low-fat dairy)
- ☐ Observe brushing, help floss. Dental exams every 6 months
- ☐ Mouth guard with contact sports

SAFETY:
- ☐ Booster seat in back seat until ~4'9" tall, shoulder strap across shoulder, not neck, can bend at knees while sitting against seat back
- ☐ ALWAYS wear helmet with wheeled activities
- ☐ Teach danger of driveways. Still shouldn't ride alone in street
- ☐ Know child's friends and families, agree on supervision
- ☐ Fire safety - family escape plan, practice it. Water safety - learning how to swin does NOT ensure safety; sunscreen
- ☐ Stranger safety - don't answer phone, door alone; before and after school supervision
- ☐ Gun safety (including BB guns)
- ☐ 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	
☐	☐	Reading: types - early readers, chapter books
☐	☐	Improving motor skills, enjoys team sports
☐	☐	Ties shoes, writes legibly
☐	☐	Imposes rules on games, understands intentional versus accidental

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________________