9-10 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 meal, positive interactions. No TV during meals or in bedrooms
- ☐ Household chores, responsibilities - respect privacy of each member of the family
- ☐ Media limitation; monitor computer use, install safety filter. Promote "media literacy"
- ☐ Model admitting mistakes, asking forgiveness, dealing with anger or disagreements

BEHAVIOR:

- ☐ Discuss school, activities; needs quiet space for homework
- ☐ Discuss puberty, increase in personal hygiene
- ☐ Discuss tobacco, alcohol, other drugs
- ☐ Consistent expectations and consequences, balanced with plenty of affection and positive reinforcement
- ☐ Expect some early adolescent behavior - challenges to rules, conflicts over independence, refusal to participate with family

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Eat breakfast! Water rather than soda or juice
- ☐ Avoid junk food - eat healthy snacks
- ☐ Brush twice, floss once. Dental exams every 6 months

SAFETY:

- ☐ Helmet and other protective sports equipement
- ☐ Pedestrian street safety
- ☐ Know friends and their families. Continue to need supervision
- ☐ ALWAYS wear helmet with wheeled activities
- ☐ Make plan for personal safety if feels unsafe
- ☐ Stranger safety - don't answer phone, door alone; before and after school supervision
- ☐ Water safety, including flotation device if in boat
- ☐ 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	
☐	☐	3-4 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 and math at grade level?
☐	☐	Improving motor skills, team sports
☐	☐	Handles frustrations and anger appropriately
☐	☐	Understands family and school rules and consequences of not following

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 _____