3-4 YEAR WELL CHILD VISIT

Hirsch Holistic Family Medicine
3525 Ensign Rd NE Ste N
Olympia WA 98506
(360) 464-9965 / (800) 897-8320 fax

Patient name: ________________________________ Date_________ Age____
Accompanied by: ____________________________ Birthdate______________

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

Yes o No o Overall, I feel confident that my child is doing well
Yes o No o I have enough help with parenting responsibilities
No o Yes o There have been recent changes or stresses in our family
No o Yes o I have concerns about sibling conflicts
No o Yes o My child attends daycare/preschool
No o Yes o My child's behavior is very challenging
No o Yes o I have questions about tantrums or discipline

____

____

NUTRITION/SLEEP

No o Yes o I have questions about my child's eating habits or growth
Yes o No o My child eats a balanced diet
Yes o No o I am happy with my child's sleep schedule
Yes o No o We use a consistent bedtime routine
Yes o No o My child sleeps in his/her own bed

____

____

VOIDING/STOOLING

Yes o No o My child is toilet trained (day and night)
No o Yes o My child has hard or painful bowel movements

____

____

DEVELOPMENT

No o Yes o I have questions about my child's development
Yes o No o My child uses 3 word sentences
Yes o No o My child's speech is understandable to others
Yes o No o My child can dress himself/herself
Yes o No o My child can pedal a tricycle and jump up and down
Yes o No o My child can draw a circle and a straight line
Yes o No o I read to my child every day

____

____

____

PREVENTION

No o Yes o My child lives with someone who smokes cigarettes
No o Yes o My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa
No o Yes o I have a family member who has had Tuberculosis
Yes o No o I always keep my child in a car seat and in the back seat
No o Yes o We have a gun at home
Yes o No o Tools and matches are kept out of reach
Yes o No o I have smoke alarms and test them regularly
Yes o No o I use sunscreen to protect my child's skin
Yes o No o My child has been to the dentist
Yes o No o I help my child brush his/her teeth
Yes o No o I give fluoride supplements daily
Yes o No o My child gets some exercise every day
No o Yes o Is there anything else you want to discuss today?

____

____

Mortality leaders: injuries due to falls, drowning, poisons, burns, auto accidents

DISCUSSION TOPICS

Parenting support
Appropriate self-expression
Conflict resolution
Time-out procedures
Setting limits/consistency
Emerging autonomy
Praise

*****

Vit D, calcium, fiber, iron sources
2% milk <16 oz./ day
Avoid sweets
Limit juice intake
Avoid mealtime struggles

*****

*****

R-PDQ if concerns
Encourage language development
Limit screen time
Playmates

Reading routines

*****

Smoking cessation
Assess TB risk

Car seat >40#, Booster until 60#
Firearms stored safely
Accident prevention/supervision
Poison control 800-222-1222
Injuries #1 cause of death
Skin cancer risk
Water safety
Tooth care routines
Promote physical activities

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PHYSICAL EXAM: (*all items examined unless crossed out. Abnormalities circled and commented on)*

Height:__________ cm (%)
Weight:__________ kg (%)
BMI: __________

T:__________
P:__________
RR:__________
BP:__________

Visual Acuity:
OD: __________
OS: __________
OU: __________

AUDIOGRAM

	LF.			RT.		
db	20	25	40	20	25	40
4000						
2000						
1000						
500						

General Appearance:	cooperative, no apparent distress, social	______
Skin:	no lesions	______
HEENT:	nares clear, TMs pearly, PERRL, normal cover test, normal oropharynx, teeth w/o caries	______
Neck:	no adenopathy or thyromegaly	______
Lungs:	clear	______
CV:	normal S1, S2, RRR without murmur normal femoral pulses	______
Abdomen:	soft, no hepatosplenomegaly or masses	______
Extremities:	hips >60 deg abduction, normal gait	______
Genitourinary:	normal male/female external genitalia	______
Neurologic:	normal tone, DTRs 2+ symmetric	______

ASSESSMENT:	PLAN:
1. Growth and developmental progress o Normal for age o Concerns __________	__________ __________
2. Immunizations	o Discussed recommended schedules, risks and benefits. o DtaP #___ o IPV #___ o MMR #___ o Hep A #___ o __________
3. Dental Health o Good o At risk o Caries	o Reviewed preventive measures o Fluoride 0.25 mg/day o ABCD referral
4. Tobacco Smoke Exposure o Yes o No	o Cessation counseling o Exposure avoidance o Referral __________
5. Screening (safety, anemia, family, TB, lead, Vit D) o No risk factors identified o Risk factors __________	o Vit D Supplement o Lead level (if at high risk) o __________
6. __________	6. __________ __________
7. __________	7. __________ __________

Next visit at __________
o Problem list updated o Allergies updated
o Med list updated o See dictated note

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__________ Provider Signature __________ Date

__________ Preceptor Signature