5 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 my child's behavior
No o Yes o My child has problems getting along with siblings/friends
No o Yes o My child is having difficulty in preschool or daycare.
No o Yes o I have questions about my child's readiness for kindergarten

____
____

DAILY ROUTINES

No o Yes o I have questions about my child's eating habits
No o Yes o I have concerns about my child's growth
Yes o No o We have regular family mealtimes _________ times/week
Yes o No o My child gets enough sleep
No o Yes o We have bedtime struggles at home
Yes o No o I limit my child's "screen time" to ______ hours a day
Yes o No o My child gets regular physical exercise
Yes o No o My child is toilet trained both day and night
No o Yes o My child has hard or painful bowel movements
No o Yes o My child has dark circles under their eyes

____
____

DEVELOPMENT

No o Yes o I have questions about my child's development
Yes o No o My child can get dressed without help
Yes o No o My child knows his/her address and phone number
Yes o No o My child's speech is easy for others to understand
Yes o No o My child can hop and balance on one foot
Yes o No o My child can draw a person with 5 parts

____

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 My child always rides in a booster seat in the back of the car
No o Yes o We have a gun at home
Yes o No o My child goes to the dentist at least once a year
Yes o No o I help my child brush his/her teeth
Yes o No o I give fluoride supplements daily (to facilitate discussion)
Yes o No o I have talked to my child about safe touch and stranger safety
Yes o No o My child always uses a bike helmet
Yes o No o My child is learning to swim
Yes o No o Is there anything else you want to discuss today?

____
____

Mortality leaders: Injuries due to falls, drowning, burns, auto accidents.

DISCUSSION TOPICS

Family roles
Consistent limits
Discipline - related consequences
Praise often
Reinforce desired behaviors
Conflict resolution skills

*****

Normal pickiness
Assess growth rate
Benefits of family meals
Bedtime routines
Media violence
Obesity/fitness
Enuresis – 20% at age 5yr
Dietary: fiber, calcium, vit D,
Iron sources

*****

RPDQ if concerns

*****

Risk of tobacco exposure
Smoking cessation
Assess TB risk
Booster seat until >60#
Firearms stored safely
Tooth care routines
Smoke detector maintenance
Burn prevention
Accident prevention/supervision
Water safety
Limit sun exposure
Injuries #1 cause of death

5 YEAR WELL CHILD VISIT

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

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

Height:__________ cm (____%) T:________ Visual Acuity: ____
Weight:__________ kg (____%) P:________ OD ________
BMI: ____________ RR:________ OS ________
BP:________ OU: ________

AUDIOGRAM

	RT.			LF.		
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 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: moves all extremities symmetrically __________
Genitourinary: normal male/female external genitalia __________
Neurologic: normal gait, DTRs 2+ symmetric __________

ASSESSMENT:

1. Normal developmental progress
   - o Normal for age
   - o Concerns __________
2. Immunizations
3. Dental Health
   - o Good
   - o At risk
   - o Caries
4. Tobacco Smoke Exposure
   - o Yes o No
5. Screening
   Other: (safety, nutrition, exercise, health, social)
   - o No risk factors identified
   - o Risk factors __________
6. __________
7. __________

PLAN:

____
____

o Discussed recommended schedules, risks and benefits.
o DtaP #___ o Hep A/B #___
o MMR #___ o ________
o IPV #___ o ________

o Reviewed preventive measures
o Fluoride 0.5 mg/day
o Fluoride varnish
o ABCD referral

o Cessation counseling
o Exposure avoidance
o Referral __________

o Hct o Lead level (if at high risk)
o PPD o ________

6. __________
____

7. __________
____

Mortality leaders: Injuries due to falls, drowning, burns, auto accidents.

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

__________ __________ __________
Provider Signature Date Preceptor Signature