Iowa Child Health and Development Record

4 year Well Exam

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:_____

GENERAL HEALTH:

Nutrition/Dental:

YES	NO	
❑	❑	Pacifier or thumb?____
❑	❑	Cow's milk____oz/day
❑	❑	Juice ____oz/day
❑	❑	Daily eats all food groups, incl. fruits and vegies
❑	❑	**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? Eat during the night?_____

DEVELOPMENT:

Screen or refer if concerns or "No" response on milestones in **bold type**

YES	NO	
❑	❑	**Family reports child can do what most 4-year-olds can do**
❑	❑	**Plays games with other children***
❑	❑	**Dresses self with help**
❑	❑	**Speaks in sentences***
❑	❑	**Speech is understandable to strangers**
❑	❑	**Understands "on" "under" "big" "little"**
❑	❑	**Copies a circle** (***autism risk**)
❑	❑	**Balances on each foot for 2 seconds**

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

MEDICAL HISTORY:

Medications:_____ Allergies:_____

Major medical illnesses:_____

Hospitalizations_____

Surgeries:_____

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare: _____

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? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ 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**

ANTICIPATORY GUIDANCE: ❑ Check if discussed

FAMILY WELL-BEING:

- ❑ Limit screen time < 2 hours per day – Monitor programming.
- ❑ No TV or DVD in bedrooms.
- ❑ Family physical and educational activities – museums, zoos, community projects.
- ❑ Structure quiet bed time routine. Read or tell stories

BEHAVIOR:

- ❑ Discuss feelings and experiences, praise when sensitive to others' feelings
- ❑ Observe child's interactions with peers, offer suggestions, and model appropriate actions.
- ❑ Encourage and ask questions - respond with short, simple, factual answers
- ❑ Set appropriate limits, praise good behavior and accomplishments.
- ❑ Assign simple chores (picking up toys, setting table).
- ❑ Structured learning/play opportunities- preschool, playgroups, Sunday school, etc.
- ❑ Teach child correct terms regarding bodies, explain privacy, discuss "rules" of behavior re: adults

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ 5+ fruits & vegetables, 3+ low-fat milk / dairy, limit junk food, NO soft drinks.
- ❑ Model good eating habits, Family meal.
- ❑ Brush twice daily with Fl toothpaste, have family dental home

SAFETY:

- ❑ Teach safety with adults - No adult should: tell child to keep secrets from parents; express interest in private; ask child for help with private parts.
- ❑ Review matches, lighters, guns.
- ❑ Teach pet, neighborhood, street, stranger safety, but **supervise** all activity near streets and driveways.
- ❑ Swimming lessons don't guarantee safety, keep within arms' length.
- ❑ If smoking in home: discuss quitting, limiting exposure

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ BP_____/_____Weight_____(_____%) Height_____(_____%)

BMI_____ (_____%) Vision Screening R 20/_____L 20/_____ Hearing: R_____ L_____

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 _____

❑ ❑ Musculoskeletal_____

❑ ❑ Neurologic _____

Results reviewed: (outside info, lab, etc.)_____

Impression:_____

_____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations:

❑ Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: ❑ No ❑ Yes_____

See current guidelines www. immunize.org/aap

LAB: ❑ Lead: Assess risk ❑ Hb or Hct: Assess risk ❑ other if indicated_____

Referral: (if indicated)_____

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229
For developmental delay or disability: **Check with local public school**

Handouts:_____

Return appointment:_____

Signature _____ Date _____