

2 - 5 YEAR VISIT

Patient Name: _____

Sponsor SSN last four: _____

Date of Last Visit: _____
Date of Birth: _____

Contact Number: Home: _____ CELL: _____

Do you have any specific concerns today? _____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/allergies Asthma Chronic ear infections Other:		Hay fever/Allergies Asthma Other:	<p><u>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</u></p> If your child takes medications, does he/she always remember to take them? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any known **allergies** your child has (drug, food, latex) _____ No Allergies

Check if anyone in the family has had:

- | | | | |
|-----------------------------------------------------|---------------------------------------|------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Long QT syndrome | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Cholesterol | | <input type="checkbox"/> Hypertrophic Cardiomyopathy | <input type="checkbox"/> Genetic or Metabolic Disease |
| <input type="checkbox"/> Heart attack before age 50 | | <input type="checkbox"/> Obesity | <input type="checkbox"/> Mental Illness |

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? Yes No

Is the child's sponsor currently deployed? Yes No Is this visit **deployment** related? Yes No

Source of Medical Information: Mother Father Patient Other: _____

Are your child's immunizations up to date? Yes No Unsure

Who does your child live with? _____

Does your child attend? Daycare Preschool Currently in school Home-schooled

Does anyone in the family smoke or is your child exposed to secondhand smoke? Yes No

Instructions for Patient Understood by Caregiver/Patient? Yes No

Do you & your child feel safe at home? Yes No

What is your preferred method for learning: Verbal Written Other: _____

Preferred language: English Other: _____

Are there cultural or religious considerations that affect your child's healthcare? No Yes

Please provide a good contact phone number: _____

Additional Hx/Prevention

Is your child a picky eater? Yes No Servings of fruits and vegetables per day? _____ # of times per week eating fast food? _____

Do you usually eat dinner as a family? Yes No Does your child usually eat breakfast? Yes No

Drink milk? Yes No Ounces per day? _____ Type of milk: Whole 2% 1% Skim

Drink juice? Yes No Ounces per day? _____ Caffeinated beverages? Yes No How many per/wk? _____

How much exposure to TV/video games/computer does your child have per day? Less than 2 hours
 Greater than 2 hours

How much physical activity does your child get per day: Less than 1 hour More than 1 hour

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems

Potty training? Currently toilet training Bladder trained Bowel trained

Does your child have a high lead risk (based on 6 questions on wall of the exam room)? Yes No

In the age group below that is closest to your child's age, please check the actions your child does:

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24 MONTHS	30 MONTHS	36 MONTHS	4 YEARS	5 YEARS
<input type="checkbox"/> Plays 'pretend' <input type="checkbox"/> Jumps in place	<input type="checkbox"/> Plays 'pretend' <input type="checkbox"/> Jumps in place	<input type="checkbox"/> Plays Make-believe <input type="checkbox"/> Throw ball overhand	<input type="checkbox"/> Dresses Without Help <input type="checkbox"/> Play Make-believe	<input type="checkbox"/> Skips <input type="checkbox"/> Articulates clearly
<input type="checkbox"/> Kicks ball forward <input type="checkbox"/> Turns single pages	<input type="checkbox"/> Point to 6 body parts <input type="checkbox"/>	<input type="checkbox"/> Balances on One Foot for 1 Second	<input type="checkbox"/> Balances on One Foot For 5 Seconds	<input type="checkbox"/> Counts to 10 <input type="checkbox"/> Is Attentive
<input type="checkbox"/> Throws ball overhand <input type="checkbox"/> Stacks 5 or more blocks	<input type="checkbox"/> Brushes Teeth with help <input type="checkbox"/> Washes and Dries Hand	<input type="checkbox"/> Builds Tower of 6t-8 Blocks	<input type="checkbox"/> Play Interactive Games with Peers	<input type="checkbox"/> Names four colors <input type="checkbox"/> Able to Tie a knot
<input type="checkbox"/> Follows 2-step commands	<input type="checkbox"/> Dresses with supervision	<input type="checkbox"/> Alternates feet walking up stairs	<input type="checkbox"/> Can Draw a Person with Three Parts	<input type="checkbox"/> Can print letters of the Alphabet
<input type="checkbox"/> Walks up and down stairs	<input type="checkbox"/> Uses 2-3 word sentences	<input type="checkbox"/> Alternates Feet Walking up Stairs	<input type="checkbox"/> Names Four Colors <input type="checkbox"/> Can copy a Cross	<input type="checkbox"/> Copies Squares and Triangles
<input type="checkbox"/> Plays interactively with other children	<input type="checkbox"/> Knows Correct Animal sounds	<input type="checkbox"/> Toilet-trained during Day. <input type="checkbox"/> Can Name a Friend	<input type="checkbox"/> Interacts with Peers <input type="checkbox"/> Jumps on One foot	<input type="checkbox"/> Can Print Letters of the Alphabet
<input type="checkbox"/> Names an Animal in a Picture	<input type="checkbox"/> Plays Interactively with other children	<input type="checkbox"/> Can Copy a circle <input type="checkbox"/> Can draw a Person	<input type="checkbox"/> Knows Name, Age, and Sex <input type="checkbox"/> Builds Tower of 6-8 blocks	<input type="checkbox"/> Understands and Follows simple commands
<input type="checkbox"/> Combines Two Different words	<input type="checkbox"/> Other Peoploe understand half of spoken words	<input type="checkbox"/> Most Spoken Words are understandable	<input type="checkbox"/> Brushes Teeth Independently	<input type="checkbox"/> Balances on one foot for 10 seconds

Weight		Visual Acuity: R 20/____ L 20/____ Both 20/____
Height		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/> No Technician Signature: _____
OFC (2 yr)		
BP		

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/Nontender/FROM/	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, spine straight	<input type="checkbox"/>
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash/skin lesions	<input type="checkbox"/>
<input type="checkbox"/>	Female:	<input type="checkbox"/> NI breasts/Tanner 1 <input type="checkbox"/> NI ext genitalia/Tanner 1	
<input type="checkbox"/>	Male:	<input type="checkbox"/> NI penis, NI scrotum, Testes down, Tanner 1, No hernia	
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> NI tone/strength/DTRs/balance. <input type="checkbox"/> CN II-XII intact	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: Lead level (2 years if applicable):

ASSESSMENT: Well child: normal growth & development for age
 ASQ performed: normal development in all areas
 M-CHAT performed (age 2 yr): normal

PLAN: Fluoride supplementation (as needed locally) Immunizations per clinic schedule

F/U: at next well child visit at ____ years, sooner if parental concerns

Patient and/or parent verbalizes understanding of treatment and plan Anticipatory guidance handout provided

PREVENTION: Dental care Safety/Falls Media
 Car/Booster Seat Tobacco avoidance
 Sun safety Exercise Nutrition

Signature: _____ Date: _____

Stamp: 26 Jan 2011, SF600

RECORDS MAINTAINED AT:		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH