Well Child Care 4 yrs

Name : DOB: Date:

Do you have any concerns today ? □ No Yes_____

Nutrition/Review of systems	**yes**	**no**	**Review of systems/symptoms**	**yes**	**no**
Appetite good ?			Any Vision Problems?		
Eats carbs, vegetables ,fruits, meat, fish ,fast foods, candy? (circle)			Any hearing problems?		
Drinks Milk? _____oz/day			Any breathing problems ?		
Drinks soda ? _____oz/day			Any heart problems ?		
Drinks juice ? _____oz/day			Any skin problems?		
Bowel movements normal ?			Any sleep concerns?		
Stool hard ? Cries with bowel movements ?			Any past bad reactions from immunizations ?		
Urination normal?			Any lead poisoning risks ?		
Immunizations up to date?			Any TB Exposure?		
Oral Health risk Assessment:					
Mother or primary caregiver had active tooth decay in past 12 mo?			Mother or primary caregiver has a dentist ?		
Frequent snacking ?			Medicaid eligible ?		
Drinks Fluoridated water or takes Fluoride supplements?			Special health care needs?		
Child has a dentist ?			Has teeth brushed twice daily?		
Developmental Questions : Can your child					
Retell stories that are familiar ?			Tell you what action is taking place in a picture?		
Pretend to write, making marks on a page that only he can read?			Play pretend games such as with toys, dolls, animals ,or even an imaginary friend?		
Use action words (verbs)?			Talk in 4 or 5-word sentences ?		
Copy a circle?			Turn paper pages in a book one at a time ?		
Walk upstairs with alternating feet?			Takes turns & follows rules while playing with other children?		
Pedal a tricycle at least 10 feet forward ?			Throw a ball overhand from a distance of 5 feet?		
Safety/anticipatory guidance issues:					
Family violence & substance abuse? circle			Media time (TV, games) more than 2 yrs /day		
Exposed to passive smoking?			Using booster car seat ?		
Medication, personal hygiene products, alcohol ,cleaning supplies ,trash containers out of reach?			Gun safety? □ chose not to answer		
Family history :					
High cholesterol ,Triglycerides			Obesity		
Diabetes			Early Heart disease ,Hypertension		

Anticipatory guidance: *□ discussed and /or handout given*

School Readiness: *□ model behavior □ be sensitive to child's feelings □ encourage play with other children □ consider preschool □ daily reading □ talk with child .*

Healthy and personal habits: *□ calm bedtime routine □ brush teeth twice daily □ daily physical activity □ TV/Media: limit TV/Media to 1-2 hrs/day □ No TV in bedroom*

Child and family involvement: *□ expect curiosity about body -answer questions using proper terms □ Safety rules with adults □ good and bad touches □ how to seek help when needed .*

Safety: *□ appropriately restrained in all vehicles □ supervise all out door play .*

Immunization: *□ Risks, benefits, side effects, alternative □ Refused, vaccine refusal form signed.*

For providers : fasting lipid age 2-10 if any of above risk factors. *2-5 yrs Wt gain 4.5 lbs/yr ,Ht gain 2.5 inch/yr. Visual acuity 20/20 by 4 yr. Bedwetting normal up to age 4 (girls),age 5 (boys).By age 4 can count to 4 and use past tense, by 5 use future tense.*

Signature of parent/guardian: **Provider signature:**