



Well Child Visit: 5-6 Years



Name: _____ DOB: _____ Date: _____

| | | | | | | | | |
|---|--|------------|--|---|------------|--|--------------|---------------------------|
| Current Medications | | | Drug / Food Allergies | | | Accompanied By | | |
| Age <input type="checkbox"/> M <input type="checkbox"/> F | | Ht. | Wt. | BMI and %ile | B/P | HR | Temp. | Interpreter: Y / N |
| Past Medical History | | | Interval History | | | Nutrition | | |
| Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child has a dental home: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Vision concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Hearing concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ F/u previous concern: <input type="checkbox"/> None _____ | | | Sleep: <input type="checkbox"/> NL _____ Elimination: <input type="checkbox"/> NL _____ Nocturnal enuresis: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Behavior: <input type="checkbox"/> NL _____ Play time >60 mins/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Activities / sports: _____ Screen time <2hr/day: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | | | Appetite: <input type="checkbox"/> NL _____ Fruits / vegetables: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Milk / calcium: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ↓ sugary drinks: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Snack habits: <input type="checkbox"/> NL _____ Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | | |
| Social / Family History | | | | Growth-Development | | | | |
| Lives at home with: _____ Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No Parent/child/sibling interaction: <input type="checkbox"/> NL _____ Cooperation/defiant behavior: <input type="checkbox"/> NL _____ School- Grade: _____ Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No Performance: <input type="checkbox"/> NL _____ Peer interaction: <input type="checkbox"/> NL _____ Teacher concerns: <input type="checkbox"/> None _____ | | | | Cognitive: <input type="checkbox"/> NL _____ Language: <input type="checkbox"/> NL _____ • Knows 4+ colors, school-ready; plays board/card games • Uses pronouns and tenses; tells simple stories in full sentences Physical: <input type="checkbox"/> NL _____ Social: <input type="checkbox"/> NL _____ • Balances on 1 foot, hops, skips; dresses self; mature pencil grasp • Engages in fantasy play; able to listen & attend; follows simple directions | | | | |
| Parental Concerns: _____ | | | | | | | | |
| Physical Exam (checked <input type="checkbox"/> = normal) | | | | | | Abnormal Findings | | |
| <input type="checkbox"/> General (Alert, NAD, socialization NL) <input type="checkbox"/> Head (No deformities, symmetric) <input type="checkbox"/> Eyes (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> Ears (Canals clear, TMs normal, orients to sounds, voice) <input type="checkbox"/> Nose (Mucosa NL, septum NL, patent) <input type="checkbox"/> Mouth/Throat (MMM, lips NL, tongue NL, no oral lesions, no erythema) <input type="checkbox"/> Teeth (Gums NL, dentition NL, no staining, caries or white spots) | | | <input type="checkbox"/> Heart (No murmurs) <input type="checkbox"/> Lungs (Clear breath sounds) <input type="checkbox"/> Abdomen (Soft, non-tender, no masses) <input type="checkbox"/> Skin (No rashes, no lesions) <input type="checkbox"/> Neuro (Tone, symmetry, strength, gait NL) <input type="checkbox"/> Extremities (Full ROM, strength/tone NL) <input type="checkbox"/> Genitalia <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge) Tanner Stage: _____ | | | | | |
| Assessment | | | | Anticipatory Guidance | | | | |
| <input type="checkbox"/> Well child <input type="checkbox"/> Normal growth and development <input type="checkbox"/> IMMS UTD <input type="checkbox"/> IMMs due _____ | | | | <input type="checkbox"/> Healthy Habits (Brush teeth 2x/day, exercise daily, limit screen time, bedtime routine) <input type="checkbox"/> Safety (Playground & stranger danger, bike helmets, pedestrian, drowning) <input type="checkbox"/> Learning (School readiness, meet teachers, show interest in school, read with your child every day) <input type="checkbox"/> Behavior (Praise, encourage, family rules, show interest in friends) <input type="checkbox"/> Nutrition (Limit high fat/sugar foods, portion size, healthy snacks, vitamins) | | | | |
| Plan | | | | | | | | |
| <input type="checkbox"/> Dental fluoride varnish every 3-6 mos. either primary care or dental office <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> TB testing based on risk factors <input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Dyslipidemia risk assessment <input type="checkbox"/> Hearing screen: <input type="checkbox"/> NL _____ (5 yo and 6 yo) <input type="checkbox"/> Vision acuity: R ___/___ L ___/___ Both ___/___ (5 yo and 6 yo) | | | | <input type="checkbox"/> Lead screening #2 (If Lead screening #2 not completed at 24 mos., 30 mos. or 3-4 yo visit) <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Education handout given | | | | |

Next Appointment: _____ Signature: _____ Date: _____



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Name: _____ DOB: _____ Date: _____

Notes:

Lined area for notes

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