Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

2 - 5 YEAR VISIT

Do you have any specific concerns today? ____

____

Any recent ER visits? ❑Yes ❑ No **When:** ______________ **Reason:**____________________________

*****(***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:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Does your child ever forget to take these medications? ❑ Yes ❑ No

Check if anyone in the family has had:

□ High Blood Pressure □ Sudden Death □ Hypertrophic Cardiomyopathy □ Genetic or Metabolic Disease

□ High Cholesterol □ Long QT syndrome □ Obesity □ Mental Illness

□ Heart attack < 50 years □ Diabetes

Please list any known allergies your child has (drug, food, latex) ____________________________

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

Is either of the child's parents on PRP status? ❑Yes ❑ No **Are your child's immunizations up to date?** ❑ Yes ❑ No ❑ Unsure

Who does your child live with? ____

Does your child attend? ❑ Daycare ❑ Preschool ❑ Kindergarten ❑ Home-schooled ❑ On base ❑ Off base

Does anyone in the family smoke? ❑ Yes ❑ No **Do you & your child feel safe at home?** ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: ______________________

Preferred language: ❑ English ❑ Other: ____________

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

Is your child a picky eater? ❑ Yes ❑ No **Servings of fruits & 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 How many ounces per day? _____ **Type of milk**: ❑ Whole ❑ 2% ❑ 1% ❑ Skim

Drink juice? ❑ Yes ❑ No How many ounces per day? _____ **Caffeinated beverages**? ❑ Yes ❑ No How many per week? ____

Does your child get at least one hour of physical activity at least 5 times per week? ❑ Yes ❑ No Type of activity: ____________

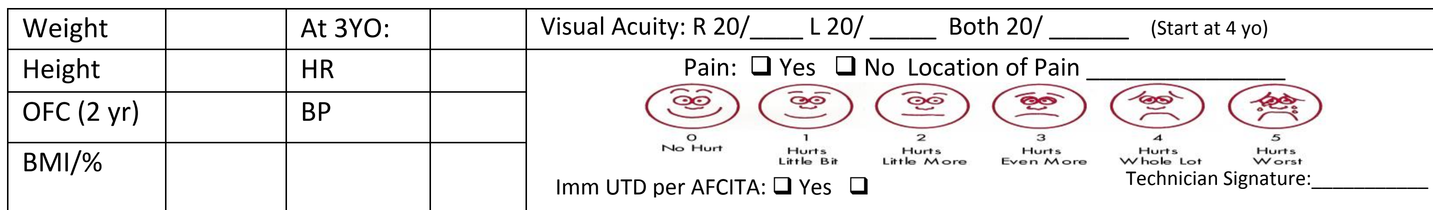
How many hours of exposure to TV/video games/computer time does your child have per day? ________

Potty training? ❑ Bladder trained ❑ Bowel trained ❑ Currently toilet training ❑ Haven't started

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

In the age group below that is closest to your child's age, please check the items your child is able to perform:

24 MONTHS	30 MONTHS	36 MONTHS	4 YEARS	5 YEARS
❑ 2-3 word sentences	❑ Names animal in picture	❑ Knows 3 of 4 colors	❑ Can sing a song	❑ Draws a person with a head, body, arms, legs
❑ Turns single pages	❑ Jumps in place	❑ Knows name/age/sex	❑ Uses prepositions (on, by, above, under, etc.)	❑ Recognizes letters
❑ Stacks 5 or more blocks	❑ Throws ball overhand	❑ Uses pronouns (he, she, I, we, etc.)	❑ Knows 3 of 4 colors	❑ Can print letters
❑ Takes off their own clothes	❑ Can draw a straight line	❑ Understands cold, hungry, tired	❑ Can draw a person with 3 body parts	❑Skips
❑ Uses 50 words or more	❑ Stacks 5 or more blocks	❑ Alternates feet walking up stairs	❑ Can copy a cross	❑Balances on one foot for 5 seconds
❑ Runs well	❑ Dresses with help	❑ Balances on a foot for 1 second	❑ Buttons clothes	❑ Plays interactive games with other children
❑ Kicks a ball forward	❑ Washes and dries hands	❑ Throws a ball overhand	❑ Dresses without help	❑Copies a triangle or square
❑ Walks up stairs	❑ Plays interactively with other children	❑ Copies a circle	❑ Jumps on one foot	
		❑ Pretends when playing	❑ Plays make-believe	
		❑ Plays interactively with other children	❑ Plays interactively with other children	



Weight		At 3YO:		Visual Acuity: R 20/____ L 20/ _____ Both 20/ _______ (Start at 4 yo)
Height		HR		Pain: ❑ Yes ❑ No Location of Pain _______________
OFC (2 yr)		BP		0 No Hurt; 1 Hurts Little Bit; 2 Hurts Little More; 3 Hurts Even More; 4 Hurts Whole Lot; 5 Hurts Worst
BMI/%				Imm UTD per AFCITA: ❑ Yes ❑ Technician Signature:___________

HPI:

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

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
❑ Optometry Referral
❑ Sports Physical Form/Health Assessment form completed/returned

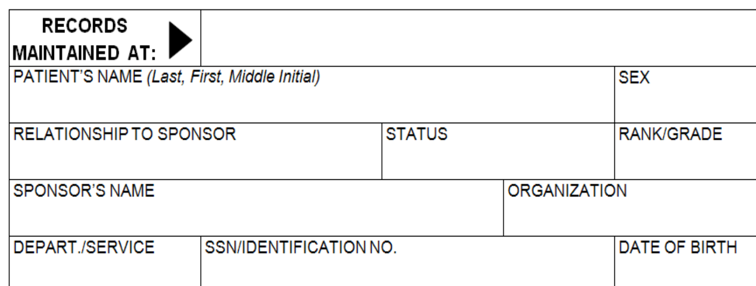
F/U: at next well child visit at ___ years, sooner if parental concerns

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

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

Signature:____
Date:
Stamp:

14 June 2012 SF 600



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

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