

# 3-5 Years

## Department of State Health Services Child Health Record Preventive Health Visit

### Family Profile and Health

No change in household since last visit  
**Child lives with:**  
 Mother  Father  Stepparent  Grandparent  
 Other  
 Total adults living in home: \_\_\_\_\_  
 Total children living in home: \_\_\_\_\_  
 Primary caretaker for this child: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
**Family's concerns/problems:**

### Development

**Parent's concerns:**  
 Developmental Assessment:  P  F  
**Type of Developmental Screen:**  
 Standardized Parent Questionnaire: \_\_\_\_\_  
 Standardized Observational Screen: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Further assessment needed:  Y  N  
**Mental Health** (see "Key Elements" on reverse side):

### Child's Health

**Allergies:**  
 Does the system review note any problems  
 or parent concerns:  Y  N  
 Explain:  
 Major illness, injury, hospitalization, surgery (since last visit):  
 Medications taken regularly – Type/Reason:

Dental Care:

### Physical Examination

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_  
 BP \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 (%) \_\_\_\_\_ (%) \_\_\_\_\_ (%) \_\_\_\_\_

<b>N</b> <input type="checkbox"/> <b>A</b> <input type="checkbox"/> <b>NE</b> <input type="checkbox"/>	<b>N</b> <input type="checkbox"/> <b>A</b> <input type="checkbox"/> <b>NE</b> <input type="checkbox"/>
____ Appearance	____ Heart/pulses
____ Head/fontanels	____ Lungs
____ Skin/nodes	____ Abdomen
____ Eyes	____ Genitalia/anus
____ Ears	____ Spine
____ Nose	____ Extremities
____ Mouth/throat	<b>Neurologic:</b>
____ Teeth	____ Muscle tone
____ Neck	____ DTRs
____ Chest/breasts	

**Additional documentation:**

### Client Information

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 SSN/Record No.: \_\_\_\_\_  
 Race/Ethnicity: \_\_\_\_\_  
 Informant/Relationship: \_\_\_\_\_  
 Medical Home: \_\_\_\_\_

### Nutrition

**Problems:** special diet, inappropriate weight gain, anemic,  
 lead poisoning, chronic GI problems, major food allergies,  
 refusal of any food group, developmental\*  Y  N  
*\*If answered yes, further assessment needed.*  
 Usual Servings Per Day:  
 Dairy  Vegetables  WIC:  Y  N  
 Breads, cereal, rice, and pasta Flouride Supplements:  Y  N  
 Meat, poultry, fish, eggs, and dry beans  
 Fruits  Vitamins:  Y  N

### Sensory

**Vision Screen:**  Normal  Abnormal  
**Hearing Screen:**  Normal  Abnormal  
**Hearing Screen Used:**  Hearing Checklist for Parents

### Health Education

<b>Injury Prevention</b>	<input type="checkbox"/> Toilet training
<input type="checkbox"/> Car safety restraints	<input type="checkbox"/> Social interaction
<input type="checkbox"/> Poisoning	<input type="checkbox"/> School readiness
<input type="checkbox"/> Fire safety	<input type="checkbox"/> Sex education
<input type="checkbox"/> Firearms	<b>Health Promotion</b>
<input type="checkbox"/> Street, water, bicycle safety	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Scissors/sharp objects	<input type="checkbox"/> Well-child care
<input type="checkbox"/> Stranger safety	<input type="checkbox"/> Dental care, appointment
<input type="checkbox"/> Teach telephone no. & address	<input type="checkbox"/> Family planning
<input type="checkbox"/> Self-safety	<input type="checkbox"/> Daycare
<input type="checkbox"/> Passive smoking	<b>Nutrition</b>
<b>Behavior</b>	<input type="checkbox"/> Healthy diet/snacks
<input type="checkbox"/> Talk/read with child	<input type="checkbox"/> Junk food
<input type="checkbox"/> Exploration	<input type="checkbox"/> Iron-rich foods
<input type="checkbox"/> Limit television	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Discipline, consistency	

### Assessment

### Plan

**Dental referral made:**  Y  N  
**WIC:**  Referred  Refused  N/A  
**Immunizations:**  Up to date  To be given today  Deferred  
**Explain:**  
**Lab:**  
 Hct/Hgb \_\_\_\_\_ Lead \_\_\_\_\_  
**Next appointment:**

Date: \_\_\_\_\_ Signature/Title: \_\_\_\_\_ Signature/Title: \_\_\_\_\_

**3-5 Years**

If used for documentation: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Key Elements**

**Systems Review**

Skin: Rashes, infections

Ears: Hearing or ear problems

Cardio/respiratory: History of murmur, trouble with breathing, wheezing

Gastrointestinal: Bowel movement frequency, soiling

Genitourinary: Dysuria, discharge

Neuromuscular: Seizures, coordination, gait

Musculoskeletal: Fractures

Eyes: Eye discharge, blinking, tearing

Nose/Mouth/Throat/Teeth: Nasal congestion

**Mental Health**

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Out of control, angry, sad, fearful, sullen, anxious

Behavior: Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, self-abuses

Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally

Thinking: Mistrustful, distracted, easily frustrated

Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems

Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

**Development**

**3 Years**

Brushes teeth with help

Tower of 6 cubes

Uses pronouns, I, you, me

Throws ball overhand

**4 Years**

Puts on T-shirt

Wiggles thumb

Expresses needs, ideas in 3-6 word sentences

Balances on 1 foot, 2 sec.

**5 Years**

Brush teeth — no help

Copies +

Carries on a conversation

Balances on 1 foot, 3 sec.

**Progress Notes**

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