

Name \_\_\_\_\_ FMP/SSN last four: \_\_\_\_\_ DOB: \_\_\_\_\_

Email Address : \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

## 2 - 5 YEAR VISIT

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	Surgeries/Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies Asthma Premie Overweight Chronic ear infections Other: (reflux)	Example circumcision		Allergies Asthma Diabetes Heart Disease Obesity	<b>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</b> <input type="checkbox"/> Infant Multivitamin 1 ml per day

**Check if anyone in the family has had:**

- High Blood Pressure
- Sudden Death
- Genetic or Metabolic Disease
- Mental Illness
- High Cholesterol
- Long QT syndrome
- Heart attack < 50 years
- Hypertrophic Cardiomyopathy

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

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

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: \_\_\_\_\_

Ethnic Origin  Filipino  Hispanic  Asian/Pacific Islander  Southeast Asian  Other  Unknown  Decline to Respond

Race  Asian/Pacific Islander  African American  Caucasian  Western Indian  Other  Unknown  Decline to Respond

Preferred language:  English  Other: \_\_\_\_\_

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

**Please See Reverse Side**

<b>RECORDS MAINTAINED AT:</b>		
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

**Diet/Exercise History:**

Current Diet Less Than 5 Servings a day Of Fruits and/or vegetables  Yes  No

Current Diet High in Fat Content and Includes High Fat Snacks  Yes  No

Current Diet High Fat and includes Frequent Fast Foods  Yes  No

Current Diet High Fat and Includes Fried Foods  Yes  No

Days a Week eating Breakfast \_\_\_\_\_ Days/week Having Dinner with Family \_\_\_\_\_

Eats Extra Large Portions  Yes  No High Sugar Beverages  Yes  No How many ounces per day? \_\_\_\_\_  
 Caffeinated Beverages  Yes  No How many per week? \_\_\_\_\_

Daily Milk Intake \_\_\_ounces per day Type of milk?  Whole  2%  1%  Skim

My child spends  Less than 2hrs per day watching TV/Video Games  More Than 2 hrs per day watching TV/Video Games  
 Less than 1 hr of active play per day  More than 1 hour of active play per day

Concerned about Bowel Movements  Yes  No Constipation  Yes  No Currently Toilet Training  Yes  No

Bladder Trained  Yes  No Bowel Trained  Yes  No Sleep Disturbances  Yes  No

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

**In the past week, has your child had:**

Fever	Yes/No	Duration?_____	Cough	Yes/No	Duration?_____
Headache	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Earache	Yes/No	Duration?_____	Abdominal pain	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Sore throat	Yes/No	Duration?_____	Other (describe)_____		

**If Ages & Stages Questionnaire NOT completed today, check the following that apply to your child:**

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



**FOR STAFF USE ONLY**

Weight	RR	Visual Acuity: R 20/____ L 20/____ Both 20/____
Height	SPO@	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/>
Temp	BP	
HR	OFC	

**HPI:**

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

Signature: \_\_\_\_\_

Date:

Stamp:

26 Jan 2011, SF600

<b>RECORDS MAINTAINED AT:</b> 		
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