4 Year Well Exam

Name

Room

Notes

Weight	T	HCT			
Height	HR	Vision	L	R	OU
BP	RR	Hearing	L	R	
	O2				

Nutrition

What foods does your child eat?	Veggies/Fruit	Protein	Junk Food	Juice	Soda
Does your child eat 3 meals per day?	Yes	No			
Does your child consume 3-4 portions of calcium per day?	Yes	No			
How much milk does your child drink?	12-16oz	<12oz	>16oz		
Does your child get exercise everyday?	Yes	No	Example?		

Dental

Do you brush your child's teeth?	Yes	No
Does your child see a dentist twice per year?	Yes	No

Sleep

Does your child sleep through the night?	Yes	No			
Does your child snore?	No	Yes	Pauses?	No	Yes

Development

Do you feel that your child sees well?	Yes	No
Do you feel that your child hears well?	Yes	No
Does your child speak clearly?	Yes	No
Can your child put clothes on and take clothes off?	Yes	No
Can your child copy a circle and a cross?	Yes	No
Can your child balance or hop on one foot?	Yes	No
Does your child get along with other children?	Yes	No
Do you read to your child?	Yes	No
Is your child in preschool?	Yes	No

Safety

Do you have the number to Poison Control?	Yes	No
Does your child use a carseat?	Yes	No
Does your childuse a helmet?	Yes	No
Does your child live in or visit a home with a pool?	No	Yes
Does your child live in or visit a home with a gunl?	No	Yes
Any smokers at home?	No	Yes

Risk Assessment

Has your child traveled outside of the U.S. in the last 6 months?	No	Yes
Exposure to anyone with a positive TB skin test?	No	Yes

Followup D/W/M

Reason:

□EHR