PEDIATRIC VISIT 3 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/____% HEIGHT_____/____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: Child care:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: CHOL TB LEAD

(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No_____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/ Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:

Education: Offer variety of nutritious foods/snacks ☐ May be picky ☐
Eats same foods as family ☐ 5 fruits/vegetables daily ☐
No sweetened beverages ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ PEDs ☐ Other: ☐ *(specify)* _____
Results: Wnl ☐ Areas of Concern:_____
Referred: Yes / No Where? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Dresses self ☐ Separates easily ☐ Plays interactive games ☐

Fine Motor: Copies: O _____ + _____ ☐ _____

Language: Understands 2of 3: cold, tired, hungry ☐
Understands 3 of 4 prepositions (block is on, under, behind in front of table) ☐ Speech clear to examiner ☐ Recognizes 3-4 colors ☐
Uses plurals ☐ Gives first and last name ☐ Knows sex (boy/girl) ☐

Gross Motor: Balances on 1 foot for 1 second ☐ Jumps well ☐
Broad jump ☐ Pedals tricycle ☐

ANTICIPATORY GUIDANCE:

Social: Needs peer contact ☐ Caution with strangers/animals ☐ Sibling rivalry ☐ Develops pride with accomplishments ☐
Caution with strangers/animals ☐

Parenting: Time out for serious misbehavior ☐ Read parenting books ☐
Help child to release energy ☐ Avoid smacking, spanking ☐
Encourage talk about feelings (instead of misbehaving) ☐
Dependency needs alternate with independence ☐
Special times alone with child ☐ Praise child ☐

Play and communication: Excursions, outdoor play, art ☐ Library ☐
Read to child ☐ Make up stories together ☐ Screen TV shows ☐

Health: Dental care ☐ Fears ☐ Physical activity ☐
Begin sex education (boy/girl differences, "private parts", etc) ☐
Masturbation ☐ Fluoride if well water ☐ Tick prevention ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Rear riding car seat ☐ Bicycle helmets ☐ Matches ☐
Riding toys in traffic ☐ Smoke detector/escape plan ☐
Poisoning (Plants, drugs, chemicals) ☐ Poison control # ☐
Hot water 120º ☐ Choking/suffocation ☐ Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐ Water safety (tub, pool) ☐
Toddler proof home ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date _____
2. Review Lead and HCT results ☐ Refer for testing if none ☐_____
3. PPD, if positive risk assessment ☐_____
4. Testing/counseling, if positive cholesterol risk assessment ☐_____
5. Dental visit advised ☐ or date of last visit_____
6. Next preventive appointment at 4 Years ☐_____
7. Referrals for identified problems:*(specify)*_____

_____

Signatures:_____