SOUTHLAKE PEDIATRICS
HEALTH SUPERVISION VISIT 4 YEARS

Name: ______________________ DOB: ________

Date of Visit ______________________ Age ________

Parental Language Barrier: ☐ N ☐ Y ____________

PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

☐ No Concerns

____

____

____

PAST MEDICAL HISTORY

Allergies __________ Immunization Reactions ________

Other ______________________

____

PRESENT HISTORY

Meds: ______________________

Diet:

Calcium ______________________

Food Groups ______________________

Exercise ______________________

Toilet Learning ______________________

Day __________ Night __________

Sleep/Naps ______________________

Dental ______________________

Brushing ______________________

DEVELOPMENT

Speech ______________________

Throws Overhead/Hops ______________________

Pedals ______________________

Knows First & Last Name ______________________

SOCIAL

Preschool, Mother's Day Out/Day Care ______________________

Behavior/Discipline ______________________

____

Daily Screen Time ______________________

FAMILY

Smoke Exposure ☐ Yes ☐ No ______________________

Other ______________________

____

____

Information completed by: ______________________

Relationship to child: ______________________

PHYSICAL EXAMINATION

Length ______ % ______ Weight ______ % ______

BMI ______ BMI% ______ BP ______ Temp ______

N	AB		COMMENTS
☐	☐	Gen. Appearance	
☐	☐	Skin	
☐	☐	Head/Fontanel	
☐	☐	Eyes/RR/Strabismus	
☐	☐	Ears/Nose/Oropharynx	
☐	☐	Neck/Nodes	
☐	☐	Chest/Lungs	
☐	☐	Cardiovascular/Pulses	
☐	☐	Abdomen	
☐	☐	Genitalia	
☐	☐	Musculoskeletal	
☐	☐	Neuro/Reflexes	
☐	☐	Hearing	
☐	☐	Vision (attempt formal) R __________ L __________	

Untestable Referred: ☐ Yes ☐ No

Screened elsewhere ______________________

ANTICIPATORY GUIDANCE

Diet

☐ Balanced meals TID

☐ Healthy Snacks

☐ Limit juice/Kool-aid/Soda

Development

☐ Reading/Library Card

☐ Encourage Language/Music

☐ TV Limits/Content

Medical Education

☐ Dental Visit

☐ Hand Washing

Health Habits

☐ Exercise/Outdoor Play

☐ No Smoking

Injury Prevention

☐ Car Seat/Seatbelts

☐ Animal Safety

☐ Personal Safety

☐ Firearm Safety

☐ Fire Safety/Smoke Detector

LABS

☐ Hgb/Hct ________ ☐ Lead Risk Factors ☐ Yes ☐ No

☐ Tb Skin Test ________ Risk Factors ☐ Yes ☐ No

IMMUNIZATIONS: ☐ DTaP/IPV ☐ MMR

☐ Other ______________________

☐ Vaccine Information Sheet given & discussed

Vaccine concerns? ☐ No ☐ Yes: Resolved Deferred Refused

Comments ______________________

If vaccines not given, form signed? ☐ No ☐ Yes

ASSESSMENT/RECOMMENDATIONS

☐ Healthy preschooler ☐ Dental Referral ______________________

____

☐ Return for 5 year checkup

______________________, M.D.

SICK VISIT – Mod 25

CC:

HPI:

MDM:

>50% of ________ min visit spent counseling