WELL CHILD ASSESSMENT – 3 YEARS

AGE:	WEIGHT:	HEIGHT:	HEAD CIRC:	BP:
TEMP:	PULSE	RESP.	HGB/HCT:	MA Signature:

Hearing 1000	2000	3000	4000	Vision		Urine			
L dB	dB	dB	dB	L	R	Protein	Sugar	Blood	Other
R dB	dB	dB	dB	Both					

INTERVAL HISTORY

Diet:
Illness:
Problems:
Immunization Reaction:
Parental Concerns:

DEVELOPMENT ☐ NORMAL ☐ ABNORMAL

- ☐ Knows Name, Age, Sex ☐ Climbs stairs, alternating feet
- ☐ Short Sentences, Speech Understood by Family, Plurals
- ☐ Builds Tower of 9 Cubes ☐ Knows One Color
- ☐ Helps Dress Self/ Washes Hands
- ☐ Rides Tricycle

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	AB	ABNORMALITIES/COMMENTS
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/ Eq Reflex			
ENT/Hearing			
Mouth/Dental"			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed)

Nutrition: 3 Meals/Day, Snacks, Avoid Junk Foods
Tobacco: Second-Hand Smoke
Safety: Streets, Refrigerator, Freezer, Electrical Outlets, Hot Water, Drowning, Lead Pottery, Folk Remedies, Smoke Detector
Parenting: Play with other Children, Toilet Training Temper Tantrums
Guidance: TV Programs, School
Dental: Routine Preventive Dental Visits, Brushing, Flossing
☐ Growing Up Healthy Brochure given

TB RISK ASSESSMENT ☐No Risk ☐Risk

ASSESSMENT:

PLAN

☐ Referral for Preventive Dental Care

Next Visit:

TOBACCO ASSESSMENT

1. Patient is exposed to Passive (second-hand) Tobacco Smoke. ☐Yes ☐No
2. Tobacco Used by Patient. ☐Yes ☐No
3. Counseled about/Referred for Tobacco Use Prevention/Cessation. ☐Yes ☐No

Patient Name/ID Number:

Exam Date: ____________________

Provider Signature