WELL CHILD 3 YEARS	Name: ☐ Female ☐ Male
Visit Date: ___/____/____	DOB: ____/____/____ Age: _____
Language: ☐ English Other:	☐ Interpreter used – Name:

BP:	T:	P:	RR:	Height: in.	Weight: lb.	BMI %:	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies: | **Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ no bottle ☐ low fat milk **WIC:** ☐ Yes ☐ No

Foods: **Seeing dentist:** ☐ Yes ☐ No

Appetite: **TB risk:** ☐ No ☐ Yes

Activity/Exercise:

Elimination:

Sleep:

Illnesses:

Childcare:

PARENTAL CONCERNS

GROWTH and DEVELOPMENT

☐ Balance on each foot (1 sec)	☐ Vocabulary approx. 500 words
☐ Knows name, age, sex	☐ Talks in sentences
☐ Cuts with scissors	☐ Separates from mother
☐ Helps in dressing	☐ 20 teeth

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet and Exercise	☐ regular meals with healthy snacks ☐ appropriate weight ☐ physical activity
Safety	☐ childproofing ☐ household safety ☐ water safety ☐ toddler car seat ☐ street dangers ☐ sun screen ☐ caution with strangers ☐ weapons
Guidance	☐ regular exercise ☐ peer play ☐ dental care ☐ discipline ☐ TV/media monitoring ☐ family dynamics ☐ parental time out

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Heart**	☐ regular rhythm ☐ no murmur
		Femoral pulses	☐ normal bilaterally
Head	☐ symmetrical	**Abdomen**	☐ soft, no masses ☐ liver & spleen normal
Eyes	☐ red reflex present R L ☐ no strabismus ☐ vision grossly normal	**Genitalia**	☐ grossly normal
		male:	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal ☐ hearing grossly normal	**Spine**	☐ normal, no sacral dimple
		Extremities	☐ no deformities, full ROM
Nose/mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction, no clicks
Teeth	☐ dentition WNL ☐ no cavities evident	**Skin**	☐ clear, no significant lesions
Neck	☐ supple / no masses	**Neurologic**	☐ normal tone ☐ normal DTR's
Lungs	☐ clear to auscultation bilaterally		

Comments:

VISION	**Near**	OD:	OS:	OU:
	Far	OD:	OS:	OU:
AUDIO - metry	**Right**	dB	Hz	☐ WNL
	Left	dB	Hz	☐ WNL
Performed by:				

ASSESSMENT: | **PLAN:**

ORDERS: ☐ Vaccine reactions, risks and follow-up explained /VIS sheets given ☐ Immunization registry entry

Immunizations- ☐ Influenza *(yearly)*

Fluoride - ☐ Rx. 0.5 mg qd ☐ Fluoride varnish ☐ **Vision screening** (objective) ☐ **Audiometry** (subjective)

Labs: ☐ Hgb. ☐ Lead blood test (if not in chart) Other:

REFERRAL: ☐ WIC Other: _____ ☐ PM 160 completed

Next appointment: ☐ 1 year Other: _____ **Provider Signature:** _____