

**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 \_\_\_\_\_

Elimination/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 \_\_\_\_\_

TV \_\_\_\_\_

**FAMILY**

Smoke Exposure  Yes  No \_\_\_\_\_

Other \_\_\_\_\_

Information completed by: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Length \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ BMI% \_\_\_\_\_

BP \_\_\_\_\_ Temp \_\_\_\_\_ Pain \_\_\_\_\_

**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 (attempt formal) R \_\_\_\_\_ L \_\_\_\_\_
- Vision (attempt formal) R \_\_\_\_\_ L \_\_\_\_\_

**ANTICIPATORY GUIDANCE**

**Diet**

- Balanced meals TID
- Healthy Snacks
- Limit juice/Kool-aid/Soda

- Firearm Safety
- Fire Safety/Smoke Detector

**Development**

- Reading/Library Card
- Encourage Language/Music
- TV Limits/Content

- Health Habits**
- Exercise/Outdoor Play
  - No Smoking

**Injury Prevention**

- Car Seat/Seatbelts
- Animal Safety
- Personal Safety

- Medical Education**
- Dental Visit
  - Hand Washing
  - Telephone

**LABS**

- Hgb/Hct \_\_\_\_\_  Lead Risk Factors  Yes  No
- Tb Skin Test \_\_\_\_\_ Risk Factors  Yes  No

**IMMUNIZATIONS:**  DTaP  IPV  MMR  Varicella

- 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