

Patient intake for 3 YEAR OLD HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Is this visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:

Verbal Sign language Written Assistive Communication Device

Preferred method of learning:

Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:

No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.

If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

Do you suspect your child is in pain? ◆ <u>Staff- Evaluate pain with FACES or FLACC Scale*</u>	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____ (◆ Staff- Request Records*)		

Review of Symptoms (Place an "X" in all categories that apply):

Hearing Concerns		Limb Pain		Ear Drainage	
Vision Concerns		Syncope (Fainting)		Sore Throat	
Snoring		Fever		Cough	
Chest Pain or Pressure		Headache		Wheezing	
Difficulty Breathing		Sinus Congestion Present		Vomiting	
Constipation		Nasal Discharge		Diarrhea	
Change in Urinary Habits		Ear Pain		Abdominal Pain	
Excessive Thirst		Pulling on Ears		Decreased Appetite	

Other: _____

Family Screening

Are any members of the household currently deployed or on extended duty outside of the immediate area?	YES	NO
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	YES	NO

Nutrition

Number of substantial breakfasts (# of days per week): _____

Number of Sweetened Drinks per day? _____

Amount of Fruit servings per day? _____

Amount of Vegetable servings per day? _____

Number of Meals with Family per week? _____

Oral Health

Has your child had a dental cleaning/ check-up in the past 6-12 months?

Yes. No.

Do you help brush your child's teeth using fluoride toothpaste?

Yes. No.

Do you have any concerns about your child's oral health?

Yes. No.

Tuberculosis (TB) Screen

Has a family member or contact had active tuberculosis? Yes. No.

Has a family member had a positive tuberculin skin test? Yes. No.

Was your child born in a high-risk country? Yes. No.

Has your child traveled to a high risk country for more than one week? Yes. No.

Lead Screen

- What is your child's primary address? _____
- Has a sibling or playmate had lead poisoning? Yes. No. Don't Know.
- Does your child reside in or visit a house or childcare facility built before 1978 which has peeling or chipping paint or has been renovated or remodeled within the last 6 months? Yes. No. Don't Know.
- Does your child come in contact with an adult whose job or hobby involves lead exposure (firing range, metal work, mining, stained glass work, renovation/remodeling)? Yes. No. Don't Know.
- Does your child live in a household eligible for Medicaid, WIC, CHIP, or a state benefits program? Yes. No. Don't Know.
- Is your child a newly arrived refugee, immigrant, or a foreign adoptee? Yes. No. Don't Know.

❖ Corpsmen: check lead exposure risk zone based on address at: <https://fortress.wa.gov/doh/wtnibl/WTNIBL/>
NOTIFY PROVIDER DURING TURNOVER of any "Yes" or "Don't Know" answers for TB or Lead Screens.

Developmental Milestones

Plays make believe	YES	NO
Toilet trained during the day	YES	NO
Copies picture of a circle with hand	YES	NO
Speak in multiple word sentences	YES	NO
Most words are understandable	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO
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Family history/Surgeries. Check all that apply.

Family History	Patient Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
◆ To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare/Preschool?	YES	NO

You are DONE! Please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****

(Below for Office Staff)

Weight: _____ kg

Height: _____ cm

Heart Rate: _____ bpm

Blood Pressure: _____

Respiratory Rate: _____ breaths/min

O2 sat (if Indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Pedivision Results:

L _____ DS: _____ DC: _____ Axis: _____

R _____ DS: _____ DC: _____ Axis: _____

Vision: Corrective lenses? YES NO

Lead Exposure Risk Zone: _____

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

3 Year Old Health Supervision

Your child's growth:

Weight: _____ lb. Percentile: _____

Height: _____ in. Percentile: _____

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process



Eating

- Have relaxed family meals without TV.
- Give your child many chances to try a new food.

Click on me to go to the
"HealthyChildren.org" Website!
An American Academy of Pediatrics
(AAP) guide to your child's milestones,
growth and development. Search by age.



Your Changing Child

- Follow a regular bed-time routine and schedule.
- Avoid the use of computers, TV, or videos to 1-2 hours or less each day.
- Take your child to the library and let them choose books.
- Read books together each day and ask your questions about the stories.
- Give your child plenty of time to finish sentences.
- Show your child how to handle anger well-time alone, respectful talk, or being active. Stop hitting, biting, and fighting right away.
- Praise your child for being kind to others. Catch them being good!
- Brush teeth twice daily with pea-sized amount of toothpaste with fluoride and spit out toothpaste.
- Take your child to the dentist at least annually.

Safety

- Use a forward-facing car safety seat in the back seat.
- Switch to a booster seat when your child reaches the weight or height limit for their car safety seat.
- Never your leave your child alone in the car, house, or yard.
- Have your child wear a good-fitting helmet on bikes and trikes.
- Never leave your child alone near water.
- If you have a gun, store in unloaded and locked with the ammunition locked separately.

Immunizations

- Annual Influenza (2 doses for first time influenza vaccination)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: <https://centercitypediatrics.com/wait-worry-panic/>

Next health supervision appointment: 4 years of age.

Patient specific guidance:
