Patient intake for 4 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? ◆ **Staff- Evaluate pain with FACES or FLACC Scale***	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 ive 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

Does your child get dressed without help?	YES	NO
Is your child creative during play?	YES	NO
Can strangers understand almost everything your child says?	YES	NO
Can you child name 4 colors?	YES	NO
Can your child hop on one foot?	YES	NO
Can your child copy a picture of a cross? +	YES	NO
Can your child catch a ball most of the time?	YES	NO
Does your child know their name and age?	YES	NO

Access to Food

• Within the past 12 months I/we were worried whether our food would run out before we got money to buy more.	Often True	Sometimes True	Never True
• Within the past 12 months the food I/we bought just didn't last and I/ we didn't have the money to get more.	Often True	Sometimes True	Never True

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO

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 or Preschool/Kindergarten?	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

BP: _____/_____

Respiratory Rate: _____ breaths/min

O2 sat (if Indicated): _____

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

Pediavision 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

4 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

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.

Eating

- Have relaxed family meals without TV.
- Offer 5 servings of vegetables and fruits each day.
- Limit candy, soft drinks, and high-fat foods.

Your Changing Child

- Follow a regular bed-time routine and schedule.
- Avoid the use of computers, TV, or videos to 2 hours or less each day.
- Read books with your child about starting school.
- Show your child how to handle anger well-time alone, respectful talk, or being active. Stop hitting, biting, and fighting right away.
- Give your child chores to do and expect them to be done.
- Brush teeth twice daily with pea-sized amount of toothpaste with fluoride and spit out toothpaste. Do not rinse out mouth with water.
- Help your child floss once each day.
- Take your child to the dentist at least annually.

Safety

- Your child should always ride in the back seat and use a car safety seat or booster seat.
- Teach your child to swim.
- Watch your child around water.
- Use sunscreen when outside.
- Have your child wear a good-fitting helmet and safety gear for biking, skating, etc.
- If you have a gun, store in unloaded and locked with the ammunition locked separately.
- Teach your child about how to be safe with other adults: no one should ask for a secret to be kept from parents, no one should ask to see private parts, and no adult should ask for help with their private parts.

Immunizations

- Kinrix #5 (Diptheria, Tetanus, Pertussis, and Polio)
- Proquad #2 (Measles, Mumps, Rubella, and Varicella)
- 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: Annually (Once Every year!)

Patient specific guidance:

_____

_____

_____