Clear Form

MINNESOTA Child and Teen Checkups

6-Year Well Visit

Patient information

Patient's name: _____

Medical record number: _____

Date of visit: _____ Date of birth: _____

Age: ____ years and ____ months Gender: _____

Accompanied by: _____

Health history

Parent or caregiver concerns today:

◯ New patient: Comprehensive prenatal, health and family history reviewed

◯ Returning patient: Interim history reviewed

Pertinent personal health history, family history or changes:

Allergies: _____

Medications (including vitamins, supplements or OTC meds):

Social history

Patient lives with: _____

Primary caregiver(s): _____

Before or after school care: _____

Housing stability, food security or concerns:

Family changes or stressors, exposure to family or community violence:

Social and community supports:

Is patient in foster care or out-of-home placement?

◯ No ◯ Yes (follow AAP guidelines: Primary Care Tools for foster care)

Daily activities

Nutrition (intake, type and quantity per day, concerns):

Physical activity (type and quantity per day):

Screen time (type and quantity per day):

Sleep (patterns, bed time, hours of sleep per 24 hours, concerns):

Elimination (regularity, concerns):

Favorite activities and interests:

Measurements

Weight: ____ kg (or ____ lbs. and ____ oz.), percentile for age: ____ %

Height: ____ cm (or ____ in), percentile for age: ____ %

BMI: ____ , percentile for age: ____ %

Blood pressure: ____ / ____ (rescreen if BP >105/66 for boys, 105/67 for girls)

Vision screening (required)

Vision concern or risk ◯ No ◯ Yes: _____

Distance vision screening (Sloan 10-foot chart recommended)

Right eye: 10/ ____ Left eye: 10/ ____ ☐ Wearing corrective lenses

◯ Pass ◯ Refer ◯ Screening exception

Near vision screening (10-foot chart with 2.5+ lenses): ◯ Pass ◯ Refer

Vision screening notes:

Hearing screening (required)

Hearing concern or risk ◯ No ◯ Yes: _____

Pure tone audiometry:

	500 Hz, 25 dB	1000 Hz, 20 dB	2000 Hz, 20 dB	4000 Hz, 20 dB
Right ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Left ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Result: ◯ Pass ◯ Rescreen ◯ Refer ◯ Screening exception

Hearing screening notes:

Developmental and social-emotional health

Surveillance (required)

Recent milestones (refer to CDC or Bright Futures milestones resources):

Parent or caregiver concerns about child's development or behavior?

◯ No ◯ Yes: _____

Peer and family relationships; school grade and academic progress:

Observations of parent-child interaction (strengths, concerns):

Mental health screening (recommended)

Instrument: ☐ Pediatric Symptom Checklist (PSC)

Result: ◯ Pass ◯ Concerns ◯ Refer

Other screening (optional): _____

Screening comments:

Risk assessment

Booster seat in back seat, always uses seat belt ◯ Yes ◯ No

Tuberculosis risk (may use MDH form) ◯ No ◯ Yes: _____

Tobacco exposure ◯ No ◯ Yes: _____

Dyslipidemia risk ◯ No ◯ Yes: _____

Fluoridated water ◯ Yes ◯ No (consider supplement)

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Review of systems

Constitutional	◯ Neg	◯ Pos		Neuromuscular	◯ Neg	◯ Pos	
HEENT	◯ Neg	◯ Pos		Skin	◯ Neg	◯ Pos	
Cardiovascular	◯ Neg	◯ Pos		Hematologic/lymph	◯ Neg	◯ Pos	
Respiratory	◯ Neg	◯ Pos		Endocrine/immune/allergic	◯ Neg	◯ Pos	
GI/GU	◯ Neg	◯ Pos		Psychosocial/behavioral	◯ Neg	◯ Pos	

Physical exam

◯ Normal ◯ Abnormal **General appearance** _____

◯ Normal ◯ Abnormal **Skin:** birthmarks, rash, lesions, scars _____

◯ Normal ◯ Abnormal **Nodes:** cervical, axillary, inguinal, other _____

◯ Normal ◯ Abnormal **Head:** shape and size, scalp, hair _____

◯ Normal ◯ Abnormal **Eyes:** lids, sclera, PERRLA, RR++, EOMs intact, corneal light reflex, cover test _____

◯ Normal ◯ Abnormal **Ears:** position, pinna, canals, TMs _____

◯ Normal ◯ Abnormal **Nose:** nare symmetry, patency _____

◯ Normal ◯ Abnormal **Mouth:** lift the lip: teeth, tongue, gums, mucosa, palate, throat, tonsils _____

◯ Normal ◯ Abnormal **Neck:** supple, ROM _____

◯ Normal ◯ Abnormal **Chest:** shape, symmetry, lung sounds, respiratory rate, Tanner stage _____

◯ Normal ◯ Abnormal **CV:** rate, rhythm, S1/S2, murmur, femoral pulses _____

◯ Normal ◯ Abnormal **Abd:** contour, umbilicus, liver, spleen, masses, bowel sounds, anus _____

◯ Normal ◯ Abnormal **GU:** labial-vaginal mucosa or penis, testes ↓ ↓, hernia, Tanner stage _____

◯ Normal ◯ Abnormal **MS:** ROM, limbs, strength, symmetry, gait, spine _____

◯ Normal ◯ Abnormal **Neuro:** tone, posture, DTRs, sensory, coordination _____

Assessment

☐ Well child or C&TC visit completed ☐ Refer to separate documentation notes

☐ Additional findings or diagnoses (specify):

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Plan

Immunization review (required)

☐ Up to date (no vaccines due today) ☐ High risk: refer to schedule

Due for: ☐ Influenza ☐ Other: _____

Given: ☐ Influenza ☐ Other: _____

Reason not given, if due: _____

Fluoride varnish application (FVA) (optional)

☐ Benefits and risks discussed, verbal consent obtained

☐ FVA applied

Dental referral (required)

☐ Verbal referral for preventative dental care

Laboratory tests (if needed)

☐ TB blood test ☐ TB skin test; date to check: _____

☐ Other: _____

Anticipatory guidance (potential resources are hyperlinked)

Topics discussed, based on patient and family needs:

☐ Consistent routines (family mealtimes, family activities, bedtime routine, Brush, Book, Bed)

☐ Developmental milestones and positive parenting

☐ Sharing books with your school-age child; limit and monitor screen time

☐ Curiosity about body; personal body safety

☐ Making healthy food choices and other nutrition information

☐ Oral health: brush 2 times and floss daily, see dentist every 6 months

☐ Safety: helmet when using bicycle or scooter, pedestrian safety

☐ Child passenger safety; look before you lock (avoiding car heatstroke)

☐ Sun protection; use sunscreen

☐ Avoid any smoke exposure

☐ Smoke alarms on every level of home, carbon monoxide detectors in sleep areas of home

☐ Poison control information given: 1-800-222-1222

☐ Firearm safety and resources

☐ Other anticipatory guidance: _____

Referrals

HIPAA Compliant Referral Condition Code (**required** for complete C&TC)

◯ Patient needs further evaluation or follow-up (write in referred-to provider and reason for referral for ST, S2, *or* AV)

◯ **ST:** Referral to follow-up here or to another provider for newly identified condition:

_____

◯ **S2:** Continue follow-up with provider for previously referred condition:

_____

◯ **AV:** Parent or guardian declines referral for:

_____

◯ **NU:** No condition requires follow-up or referral

Additional recommendations

☐ Medications, supplements, treatments:

☐ Help for housing, food access (SNAP or other resources) or other family concerns:

☐ Next well visit in one year, or sooner if needed: _____

☐ Quitting tobacco encouragement, resource provided

☐ Other community referrals, resources, education:

☐ Other recommendations (follow-up, actions to take at home, etc.):

PROVIDER SIGNATURE, CREDENTIALS			DATE
CLINIC NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE