



**West Virginia  
HealthCheck Program  
PREVENTIVE HEALTH SCREEN**

**3 yrs**

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_ **SEX** \_\_\_\_\_ **WGT** \_\_\_\_\_ **HGT** \_\_\_\_\_ **BP** \_\_\_\_\_ **SCREEN DATE** \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_ **CURRENT MEDS** \_\_\_\_\_

**HISTORY**

Concerns and questions \_\_\_\_\_  
 \_\_\_\_\_  
 Follow up on previous concerns \_\_\_\_\_  
 \_\_\_\_\_  
 See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_

**SOCIAL/FAMILY HISTORY**

See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_  
 Family Situation     No change \_\_\_\_\_  
 Parents working outside home     Mother     Father  
 Child care     Yes     No     Type \_\_\_\_\_  
 Preschool     Yes     No     Type \_\_\_\_\_  
 Changes since last visit     Yes     No \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT HEALTH INDICATORS**

See Initial History     No change \_\_\_\_\_  
 Interval History Change \_\_\_\_\_  
 Nutrition Eating Habits \_\_\_\_\_  
 \_\_\_\_\_  
 Vitamins/Fluoride \_\_\_\_\_  
 Source of Water \_\_\_\_\_  
 Elimination     NL \_\_\_\_\_  
 Sleep     NL \_\_\_\_\_  
 Behavior     NL \_\_\_\_\_  
 Toxic Exposure  
 Passive Smoking     Yes     No  
 Lead Risk     High Risk     Low Risk  
 Lives in or regularly visits a house/ child care facility built before 1970 or that has been recently remodeled?  
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?  
 Has a sibling or playmate who has or did have lead poisoning?  
 Tuberculosis Risk     High Risk     Low Risk  
 Exposure to TB  
 Radiographic or clinical findings  
 Immigrant from areas with high prevalence  
 Residence/travel in area with high prevalence  
 Homelessness  
 HIV infection or living with person who has HIV  
 Other medical risk factors  
 Development  
 Growth     Plotted on growth chart  
 Gross Motor:  
 Jumps in place

**CURRENT HEALTH INDICATORS (CONTINUED)**

Up/down stairs alternating feet  
 Kicks ball  
 Rides a tricycle  
 Fine Motor:  
 Uses cup, spoon and fork  
 Copies a circle and cross  
 Self-care skills (feeding, dressing)  
 Has manual dexterity  
 Communication:  
 Uses sentences of 3-4 words, short paragraphs  
 Uses plurals, pronouns  
 Speaks intelligibly  
 Cognitive:  
 Knows name, age and sex  
 Names most common objects  
 Follows 2-step instructions  
 Gender differences  
 Social:  
 Shows early imaginative behavior  
 Listens to stories  
 Plays interactive games with peers (able to take turns)  
 Vision Acuity Screen (objective) Right \_\_\_\_\_ Left \_\_\_\_\_  
 Hearing Screen (objective) Right \_\_\_\_\_ Left \_\_\_\_\_

**PHYSICAL EXAMINATION**  
 ✓=NL  
 General Appearance     Skin  
 Head  
 Eyes     Red Reflex     Strabismus  
 Ears     External     Internal  
 Mouth     Throat     Nose  
 Lungs  
 Heart  
 Abdomen  
 Genitalia     Male     Female  
 Extremities     Back  
 Femoral pulses Right \_\_\_\_\_ Left \_\_\_\_\_  
 Neurological  
 Abnormal findings/comments \_\_\_\_\_

**ANTICIPATORY GUIDANCE/HEALTH EDUCATION**

Discussed     Handouts given  
 Nutrition:     Low fat dairy     Food groups  
 3 balanced meals/day     2-3 snacks/day  
 Limit high fat snacks     Feeds self  
 Variable appetite     Limit sweets

**ANTICIPATORY GUIDANCE/HEALTH EDUCATION (CONT)**

Dental/oral care  
 Elimination  
 Sleep  
 Development/Behavior:  
 Social     Motor skills  
 Communication     Set limits  
 Physical     Discipline/time out  
 Cognitive skills     Health/safe habits  
 Family relationship  
 Injury Prevention:  
 Auto/car seat     No shaking  
 Poisons     Burns  
 Falls     Smoke detector  
 Lighters/matches     Water heater  
 Electrical outlets     Fire retardant clothes  
 Choking     Sun  
 Sharp objects     Stoves/heaters  
 Water     Guns

**PLAN**

Immunizations (see Vaccine Administration Record)  UTD  
 Labs  
 Hgb/Hct     Blood Lead Level if child has not had one  
 PPD if 1 or more risk factors  
 Other \_\_\_\_\_

**REFERRALS**

Development  
 One delay -re-evaluate in 1 month  
 Two or more delays - **Referred to:**  
 Blood lead level 10>  
 Dentist \_\_\_\_\_  
 Vision 20/40> \_\_\_\_\_  
 Further Medical Treatment/Diagnosis - **Referred to:**  
**FOLLOW UP /NEXT VISIT:**

\_\_\_\_\_  
**Please Print Facility or Clinician Name**

\_\_\_\_\_  
**Signature of Clinician**



**WVDHHR/BPH/OMCFH/HC/HC-3Y 4-04**