

3 years - well child care

Name: _____

Household

Who lives in the home (e.g. Father, mother, brother, etc.)? _____

Does your child attend daycare?	Yes	No
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Development

Stands on one foot	Yes	No
Walks up and down stairs	Yes	No
Rides a tricycle	Yes	No
Hops briefly on one foot	Yes	No
Cuts with small scissors	Yes	No
Has a conversation with 2 or 3 sentences together	Yes	No
Toilet trained or showing interest	Yes	No
Combines sentences using and, or	Yes	No
Identifies at least 4 colors	Yes	No
Counts to 5	Yes	No
Gives direction to other children	Yes	No
Plays a role in pretend games	Yes	No

Nutrition

Drinking 16 oz. of skim or 1-2% milk	Yes	No
well balanced diet	Yes	No
Well water or city water?	Well	City

Bowel habits

How many stools a day?

What do the stools look like (soft, seedy, loose)? _____

Sleep Pattern

Sleeping overnight?	Yes	No
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Safety

Is car seat in the back seat and rear facing?	Yes	No
Is your child exposed to tobacco smoke?	Yes	No
Are there any improperly stored firearms in the home?	Yes	No
Is the hot water temperature set low enough to prevent accidental burns?	Yes	No
Are there working smoke detectors in the home?	Yes	No

Miscellaneous

Any questions or concerns? If yes, what are they?	Yes	No
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Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- If born before 1/1/2015, lives in a 2004 "at-risk" zip code?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead.
- Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Vision Test: Left 20/ ____ Right 20/ ____

Hearing Test: