3 Years – well child care **Patient Name:______________________D.O.B_______**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

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

Does your child attend daycare?_______________________________________ ▢ Yes ▢No

Development

Talks with you in conversation using at least 2 back-and-forth exchanges_________ ▢ Yes ▢No
Asks who, what, where, or why questions, like "Where is mommy/daddy?"_______ ▢ Yes ▢No
Says what action is happening in a picture when asked,__________________ ▢ Yes ▢No
like running, eating or playing
Says first name when asked____ ▢ Yes ▢No
Talks well enough for others to understand, most of the time________________ ▢ Yes ▢No
Draws a circle when you show them how_______________________________ ▢ Yes ▢No
Avoids touching hot objects, like a stove, when you warn them_______________ ▢ Yes ▢No
Strings items together, like large beads or macaroni_______________________ ▢ Yes ▢No
Puts on some clothes by themselves, like loose pants or a jacket______________ ▢ Yes ▢No
Uses a fork____ ▢ Yes ▢No
Calms down within 10 minutes after you leave them, like at child care drop off_____ ▢ Yes ▢No
Notices other children and joins them to play___________________________ ▢ Yes ▢No

Nutrition

Does your child drink milk? If so what kind_________ ▢Whole Milk ▢Soy Milk ▢Other __________
Do they drink approximately 16oz (480ml) per day ? ____________ ▢ Yes ▢No
Avoiding excess added sugars (juice, candy, sweets) and animal fats?_ ▢ Yes ▢No
Consuming green vegetables?____________________________ ▢ Yes ▢No

Bowel habits

How many stools does you child have per day? ____
What do the stools look like (soft, formed, hard)? _______________________________________
Is your child showing interest in or has completed toilet training?_____ ▢ Yes ▢No

Sleep Pattern

Sleeps through the night in their own bed?____________________ ▢ Yes ▢No

Safety

Is your child's car seat in the back seat?______________________ ▢ Yes ▢No
Is your child exposed to tobacco smoke?______________________ ▢ Yes ▢No
Are there any improperly stored firearms in the home?___________ ▢ Yes ▢No
Is the home childproofed?__________________________________ ▢ 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

Please share any concerns that you have about your child here:

____

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Please complete both sides of this form

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?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or 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 stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight ____

Height ____

Head Circumference ________________________________

Blood Pressure ___________________________________

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: Passed Failed

Please complete both sides of this form