4 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

Says sentences with at least 4 words_____ ▢ Yes ▢No

Says some words from a song, story or nursery rhyme_____ ▢ Yes ▢No

Talks about at least 1 thing that happened during the day, like _____ ▢ Yes ▢No
"I played soccer."

Answers simple questions, like "What is a coat for?" or "What is _____ ▢ Yes ▢No
a crayon for?"

Names a few colors of items_____ ▢ Yes ▢No

Tells what comes next in a well-known story_____ ▢ Yes ▢No

Draws a person with at least 3 body parts_____ ▢ Yes ▢No

Catches a large ball most of the time_____ ▢ Yes ▢No

Serves themselves food or pours water, with adult supervision_____ ▢ Yes ▢No

Unbuttons some buttons_____ ▢ Yes ▢No

Holds crayon or pencil between fingers and thumb (not in a fist)_____ ▢ Yes ▢No

Pretends to be something else during play (teacher, superhero, dog)_____ ▢ Yes ▢No

Asks to go play with children if none are around, like "Can I go play with Alex?"_____ ▢ Yes ▢No

Comforts others who are hurt or sad, like hugging a crying friend_____ ▢ Yes ▢No

Avoids danger, like not jumping from tall heights at the playground_____ ▢ Yes ▢No

Likes to be a "helper"_____ ▢ Yes ▢No

Changes behavior on the basis of where he/she is (place_____ ▢ Yes ▢No
of worship, library, playground)

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 throughout the night in their own bed?_____ ▢ Yes ▢No

Safety

Is your child's car seat or booster seat in the back seat?_____ ▢ Yes ▢No

Wears a helmet with cycling/boarding/skating?_____ ▢ Yes ▢No

Is the home childproofed?_____ ▢ 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

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

_____

_____

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 _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: Passed Failed

Please complete both sides of this form