Patient Name

Date of Birth

Well Child Check: 3 year visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No ☐ Yes ☐

Has your child had any reactions to vaccinations in the past? No ☐ Yes ☐

Development:

Can your child kick a ball? Jump off the ground? Yes ☐ No ☐

Can your child pedal a tricycle? Yes ☐ No ☐ Unsure ☐

Does your child speak in sentences (3 words or more)? Yes ☐ No ☐

Does your child use plurals (cars, balls, etc)? Yes ☐ No ☐

Does your child understand concepts such as cold, tired, hungry? Yes ☐ No ☐

Is your child's speech at least 50% understandable to most people? Yes ☐ No ☐

Does your child know his/her name, age and gender? Yes ☐ No ☐

Does your child start to say the ABC's? Yes ☐ No ☐

Does your child identify several colors? Yes ☐ No ☐

Can your child help with getting him/herself dressed, brushing teeth? Yes ☐ No ☐

Does your child alternate feet when walking up the stairs? Yes ☐ No ☐

Can your child copy a circle and a cross (+)? Yes ☐ No ☐

Is your child potty trained? Yes ☐ No ☐

Do you and your child read together daily? Yes ☐ No ☐

Do you have concerns about how your child sees? No ☐ Yes ☐

Do you have concerns about how your child hears? No ☐ Yes ☐

Do you have concerns about how your child speaks? No ☐ Yes ☐

Dental Health:

Do you help your child brush and floss his/her teeth daily? Yes ☐ No ☐

Does your child have a dentist? Yes ☐ No ☐

Does your child's primary water source contain fluoride? Yes ☐ No ☐ Unsure ☐

If no, do you give your child a fluoride supplement? Yes ☐ No ☐ N/A ☐

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV/play video games or use a tablet or smart phone more than 2 hours per day? No ☐ Yes ☐

Does your home have a working smoke detector? Yes ☐ No ☐

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes ☐ No ☐ N/A ☐

If your home has more than one floor, do you have safety guards on the windows? Yes ☐ No ☐ N/A ☐

Does your home have cleaning supplies/medicines/matches locked away? Yes ☐ No ☐

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes ☐ No ☐

Do you always stay with your child when she/he is in the bathtub? Yes ☐ No ☐

Do you and your child spend time near water (pool, river or lake)? No ☐ Yes ☐

If so, is your child always safely supervised? Yes ☐ No ☐ N/A ☐

Do you use sunscreen when your child is outdoors? Yes ☐ No ☐

Do you always place your child in a car seat in the back seat? Yes ☐ No ☐

Is your car seat the right one for the age and size of your child? Yes ☐ No ☐

Do you always check for children before backing your car out? Yes ☐ No ☐

Does your child spend time in a home where a gun is kept? No ☐ Yes ☐ Skip ☐

If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes ☐ No ☐ N/A ☐

Does your child wear a helmet when riding a tricycle, bike or scooter? Yes ☐ No ☐ N/A ☐

Has your child ever witnessed or been a victim of abuse or violence? No ☐ Yes ☐

Does your child spend time with anyone who smokes? No ☐ Yes ☐

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950? No ☐ Yes ☐

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)? No ☐ Yes ☐

Does your child have a sibling or playmate who has or did have lead poisoning? No ☐ Yes ☐

Does your child take any imported remedies or supplements? No ☐ Yes ☐

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No ☐ Yes ☐
This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate ***for one month or more***? (Countries other than those listed above) No ☐ Yes ☐

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No ☐ Yes ☐ Unsure ☐

Is your child immunosuppressed (currently or planned)? No ☐ Yes ☐
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your child sleep at night? _____hours

How many hours does your child nap throughout the day? _____hours

Nutrition/Physical Activity:

What type of milk do you give your child? (circle one) [Whole] [2%] [Nonfat] [Other]

How many ounces of milk does your child drink per day? _____oz

How much juice does your child drink in 24 hours? _____oz

Is your child eating fruits and vegetables at least two times per day? Yes ☐ No ☐

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes ☐ No ☐

Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week? No ☐ Yes ☐

Does your child drink soda, sports drinks, energy drinks or other sweetened drinks more than once per week? No ☐ Yes ☐

Does your child eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)? Yes ☐ No ☐

Do you have trouble affording to buy food for your family? No ☐ Yes ☐

Does your child play actively most days of the week? Yes ☐ No ☐

Do you have any concerns about your child's weight or feeding? No ☐ Yes ☐

Elimination:

Does your child have bowel movements on a regular basis with a normal (soft) consistency? Yes ☐ No ☐

Please list any medications or supplements your child is taking: _____

_____

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues: _____

_____

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

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Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver.12-12-17