



### WELL CHILD CHECK UP: 3 – 5 Years

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**Interval History:**

Has your child been ill since the last check-up?  Yes  No If yes, please describe: (Hospitalization, surgery, illness, etc.) \_\_\_\_\_

What medications, supplements, or vitamins is your child taking, if any? \_\_\_\_\_

Does your child have any allergies?  Yes  No What kind? \_\_\_\_\_

Has your child had a reaction to shots before?  Yes  No If yes, describe: \_\_\_\_\_

What concerns or questions do you have about your child, if any? \_\_\_\_\_

**Nutrition:**

How is your child's appetite?  Good  Average  Poor Does your child eat paint or dirt?  Yes  No

How many times a day does your child brush his/her teeth? \_\_\_\_\_ How many meals per day? \_\_\_\_\_

Milk:  Whole milk  2% or 1%  Skim  Soy Cups of milk/day \_\_\_\_\_ Cups of juice/day \_\_\_\_\_

Servings of meat per day? \_\_\_\_\_ Servings of vegetables per day? \_\_\_\_\_ Cans/cups of soda per day? \_\_\_\_\_

Any problems with urine output or bowel movements? \_\_\_\_\_

**Development / Language / Motor:**

How much of your child's language could a stranger understand? \_\_\_\_\_% (for example: 25, 50, 75, 100%?)

Does your child...  Speak in sentences  Ask "Why" questions  Understand instructions

*Check box only if YES*  Walk up/down stairs without help  Feed him/her self with fork/spoon

Brush his/her teeth  Run  Skip  Use the toilet by him/herself

Copy a circle  Copy a square  Ride a bike  Write his/her name  Know his/her phone number

Does your child know...  Colors  Body parts  Letters  Numbers (up to \_\_\_\_\_#)  Address

Do you have any concerns about your child's development? If yes, please describe: \_\_\_\_\_

**Safety / Home:**

Do you use a  car seat,  booster seat,  seat belt? Do you have a working smoke detector?  Yes  No

Is your child exposed to smoke?  Yes  No Is there a gun in your home?  Yes  No

Is your child (circle): happy sad playful shy? Is he/she able to get along with others?  Yes  No

Who lives in your household? \_\_\_\_\_

Any pets? If yes, what kind? \_\_\_\_\_

Is your child in childcare / school? Please describe: \_\_\_\_\_

Has anyone physically abused or threatened you or your children?  Yes  No

**TB Screening Questions:** Has your child been around anyone ... who has HIV or uses IV drugs?  Yes  No

... who lives in a group or nursing home?  Yes  No ... who has traveled to another country?  Yes  No

... who has been homeless or incarcerated (in jail)?  Yes  No

**Behavior:**

What do you do when your child misbehaves? \_\_\_\_\_

Any behavior problems?  Yes  No If yes, describe: \_\_\_\_\_

How many hours does your child sleep at night? \_\_\_\_\_ During the day? \_\_\_\_\_

How many hours of TV does your child watch per day? \_\_\_\_\_

Do you want to discuss (check if Yes):  Toilet training  Temper tantrums

Eating problems  Sleep problems

→ Please indicate relationship of person completing form: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_