

# Well Child Check: 3 Year Visit



Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions, it will help your clinicians spend more time discussing those specific issues that concern you, PLEASE FILL OUT BOTH SIDES.

Can your child pedal a tricycle or other toy?	YES	NO	UNSURE
Can your child throw a ball overhand?	YES	NO	UNSURE
Can your child get dressed with your help (or on own)?	YES	NO	UNSURE
Can your child copy a circle?	YES	NO	UNSURE
Are at least three-fourths of the words your child uses understandable to most people?	YES	NO	UNSURE
Does your child do pretend play using toys?	YES	NO	UNSURE
Does your child know his or her name, age and sex?	YES	NO	UNSURE
Does your child join other children in play?	YES	NO	UNSURE
Does your child count to three or more?	YES	NO	UNSURE
Does your child ask questions?	YES	NO	UNSURE
Does your child usually drink more than 4 oz of juice or sweetened drinks daily?	YES	NO	UNSURE
How many ounces of milk does your child drink in 24 hours? _____ oz.			
	Whole	Low Fat	Non-Fat
Is your child completely weaned from the bottle?	YES	NO	UNSURE
Does your child eat meat (such as fish, chicken, beef, pork)?	YES	NO	UNSURE
Do you and your child read together daily?	YES	NO	UNSURE
Does your child typically watch MORE than 2 hours of TV, computer/video games, etc, daily?	YES	NO	UNSURE
Is your child toilet trained during the daytime?	YES	NO	UNSURE
Do you usually protect your child with sunscreen/hats/other measures when outdoors?	YES	NO	UNSURE

Does your child wear a helmet if she/he is riding a tricycle?	YES	NO	UNSURE
Does your child see a dentist at least once a year (every 6 months is best)?	YES	NO	UNSURE
Does your tap water contain fluoride?	YES	NO	UNSURE
Are there guns at your home, or any home your child regularly visits?	YES	NO	UNSURE
Does your child have access to a pool that does not have a locked gate?	YES	NO	UNSURE
Do you have any other safety concerns at your home? If so, please describe:			
Who provides daytime care for your child?			
Is your child on any medications or supplements including vitamins? If so, please list below:			
Do you have any international travel plans prior to your child's fourth birthday? If so, when and where?			
<b>Risk Assessment for Tuberculosis Exposure/Infection:</b>			
Has a family member or contact had tuberculosis disease?	YES	NO	UNSURE
Since your child's last well check has a family member or contact had a positive tuberculosis test?	YES	NO	UNSURE
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand or western European countries)?	YES	NO	UNSURE
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand or western European countries)?	YES	NO	UNSURE
Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? If so, please describe:			