3 Year Well Visit Questions **Name, date of birth** ____

Who is your child here with today? ____

Illnesses, injuries, surgeries, hospitalizations since last visit? ____

Medications: ____

Medication allergies: ____

Food allergies: ____

Immunization reactions: ____

Is your child taking vitamins? (Circle what applies) Fluoride, Multi-vitamin, None

Parents or grandparents with high cholesterol or heart disease? YES, NO

SOCIAL:

Changes in child's environment? ____

Who lives with the child in your home? #____Mom, #____ Dad , #____ Brother, # ____ Sister, ____________________other

Water source: CITY, WELL, BOTTLED

Tobacco exposure: YES, NO

Pets?___________________________

Daycare: YES, NO Has your child seen a dentist? YES, NO

FEEDING:

Milk: Whole, 2%, 1%, Soy?____

Ounces of sweetened beverages per day: ________________

Is your child off of the bottle? YES, NO

Is your child off of the pacifier? YES, NO

Does your child eat a good variety of table foods? YES, NO

ELIMINATION: Any issues urinating or with bowel movements? _____________________________________

SLEEP: how many hours does your child sleep without waking? ______________________________

Does your child snore? YES, NO

BEHAVIOR (circle one) No problems, Frequent tantrums, Irritable, Disobedient

DEVELOPMENT:

1- Pedals a tricycle: YES, NO

2- Walks up and down stairs: YES, NO

3- Kicks a ball: YES, NO

4- Copies a circle: YES, NO

5- Holds a pencil correctly: YES, NO

6- Turns pages one at a time: YES, NO

7- Completes 3-4 piece puzzle: YES, NO

8- Knows name, age, gender: YES, NO

9- Speaks clearly: YES, NO

10- Says 3-4 word sentences: YES, NO

11- Names most body parts: YES, NO

12- Identifies 3 colors: YES, NO

13- Shows affection openly: YES, NO

14- Separates easily from parent: YES, NO

15- Cuts with scissors: YES, NO

16- Puts on shoes without laces: YES, NO

17- Uses pronouns correctly: YES, NO

Lead Questions:

Does your child live in or often visit a house that had been built before 1978? YES, NO

Does your child live in or often visit a house that is being remodeled or is having paint removed? YES, NO

Does your child live with or often visit another child who has an elevated lead level? YES, NO

Does your child have a hobby that uses lead? YES, NO

Does your child chew on or non-food items like paint chips or dirt? YES, NO

Does the child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? YES, NO

TB Questions

Does your child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or abnormal chest x-ray?

YES, NO, UNKNOWN

Has your child been in close contact with a person sick with active TB? YES, NO, UNKNOWN

Has your child been exposed to anyone who has been in jail or prison in the past 5 years? YES, NO, UNKNOWN

Was your child born outside of the U.S. or has your child traveled outside the U.S.? YES, NO, UNKNOWN

Does your child have a household member who was born outside the U.S. or who has traveled outside the U.S.? YES, NO, UNKNOWN

Has your child been exposed to any of the following?

HIV infected individuals? YES, NO, UNKNOWN

Homeless persons YES, NO, UNKNOWN

Users of IV and/or other street drugs? YES, NO, UNKNOWN

Residents of nursing homes or group home? YES, NO, UNKNOWN

Migrant workers? YES, NO, UNKNOWN

Does your child have HIV, or risk factors for HIV or any other health problem that could lower the immune system? YES, NO, UNKNOWN

Has your child ever been in jail? YES, NO, UNKNOWN

{International Travel: Exposure to anyone who has traveled outside the United States in last 60 days: YES, NO,