OBERLIN ROAD PEDIATRICS

Well Child Check: 3 Year Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your child take any medications or supplements, including vitamins? □ No □ Yes:_____

Does your child have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your child's hearing? □ No □ Yes: _____

Does your child see any specialists outside of ORP? □ No □ Yes: _____

Dental Health:

Has your child seen a dentist? □ Yes □ No (see our list)

Does your water source contain fluoride? □ Yes (=city water) □ No (=well water)

Are you brushing your child's teeth with fluoridated toothpaste 2x a day? □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis result? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? □ No □Yes

Nutrition:

Are they usually getting 2-3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of milk a day? □ No □ Yes

What type of milk is your child drinking? □ Whole Milk □ 2% □ 1% □ other _____

Are they eating iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □No

Developmental Questions: Can your child….

Calm down within 10 min after you leave them, like at daycare dropoff?	Yes	No
Notice other children and join them to play?	Yes	No
Talk with you in conversation using at least 2 back and forth exchanges?	Yes	No
Ask who, what, where, or why questions like "where is mommy/daddy?"	Yes	No
Say what action is happening in a picture when asked, like running, eating, or playing?	Yes	No
Says first name when asked?	Yes	No
Talk well enough for others to understand, most of the time?	Yes	No

Draw a circle when you show them how?	Yes	No
Avoid touching hot objects, like a stove, when you warn him?	Yes	No
String things together, like large beads or macaroni?	Yes	No
Put on some clothes by themself, like loose pants or a jacket?	Yes	No
Use a fork?	Yes	No

Who takes care of your child during the day? _____
Are parents: single married divorced separated
Have there been major changes lately in your baby's or family's life? _____
Will your child travel internationally in the next year? If yes, where and when? _____

Are you happy with your child's sleep?	Yes	No
Do you have a regular bedtime and mealtimes?	Yes	No
Is your child fully toilet trained (urine and stool) for the daytime?	Yes	No
Are family members loving and affectionate with one another?	Yes	No
Do you praise your child when they are being good?	Yes	No
Do you have ways to constructively handle anger and settle disputes in your family?	Yes	No
Does everyone who cares for your child set the same limits for your child?	Yes	No
Do you allow your child to make choices, such as what clothes to wear or books to read?	Yes	No
Do you offer your child at least 5 servings of vegetables or fruits a day?	Yes	No
Do you let your child decide what to eat and how much?	Yes	No
Is your child willing to try new flavors and textures?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes
Does your child engage in fantasy play with dolls, toy animals, or blocks?	Yes	No
Do you spend time alone with your child doing things you both enjoy?	Yes	No
Does your child have chances to play with other children (such as playdates or preschool)?	Yes	No
Do you help your child learn how to take turns?	Yes	No
Do you read, sing songs or play word games with your child every day?	Yes	No
Does your child play actively for at least 1 hour a day?	Yes	No
How much time every day does your child spend watching devices/screens?	_____	
Is your child always in a 5-point car seat in the back seat of the car?	Yes	No
Do you cut foods such as grapes and hot dogs into small pieces to prevent choking?	Yes	No
If you have a pool (or hot tub/spa/pond), does it have a locked gate?	Yes	No
Do you always stay within arm's reach of your child when they are in water?	Yes	No
Does your child wear a life jacket when on a boat or in open water?	Yes	No
Does your child spend time in a place with an unlocked gun?	No	Yes
Do you feel safe in your home and community?	Yes	No
Has your partner or another significant person in your life ever hurt you or your child?	No	Yes
Do you have the things you need to take care of your child?	Yes	No
Does your home have enough heat/AC, hot water, electricity?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out?	No	Yes
Is there anyone in your child's life whose alcohol/drug use concerns you?	No	Yes