OBERLIN ROAD PEDIATRICS

Well Child Check: 3 Year Visit

Your Child's Name: _____

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	
Can your child throw a ball overhand?	Yes	No	
Can your child get dressed with your help (or on own)?	Yes	No	
Can your child copy a circle?	Yes	No	
Are at least three-fourths of the words your child uses understandable to most people?	Yes	No	
Does your child know his or her name, age and sex?	Yes	No	
Does your child join other children in play?	Yes	No	
Does your child count to three or more?	Yes	No	
Does your child ask questions?	Yes	No	

Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	
How many ounces of milk does your child drink in 24 hours? _____ oz.	Whole	2%	1%
Is your child completely weaned from the bottle?	Yes	No	
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	

Do you and your child read together daily?	Yes	No	
Does your child typically watch > 1 hour of TV / Computer / Video games, etc. daily?	No	Yes	
Is your child toilet trained during the daytime?	Yes	No	
Do you usually protect your child with sunscreen /hats /other measures when outdoors?	Yes	No	
Does your child wear a helmet when he/she is riding a tricycle?	Yes	No	
Does your child have access to a pool that does **NOT** have a locked gate?	No	Yes	

Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	
Does your tap water contain fluoride? City water contains fluoride.	Yes	No	
Do you help your child brush their teeth twice a day?	Yes	No	

Have there been any changes in your family since last visit? _____

_____

Who provides day time care for your child? _____

Is your child on any medications or supplements, including fluoride or 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?

_____

CONTINUES ON OTHER SIDE

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Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	No	Yes	
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes	
Was your child born in a high-risk country (Countries other than the United States,Canada, Australia, New Zealand, or western European countries)?	No	Yes	
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)?	No	Yes	

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? No Yes

_____

_____

_____

Any concerns about your child's hearing? No Yes

CONTINUES ON NEXT PAGE

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SOCIAL DETERMINANTS OF HEALTH

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?	No	Yes	
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	No	Yes	

Interpersonal Safety

Do you feel physically or emotionally unsafe where you currently live?	No	Yes	
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	No	Yes	
Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	Yes	