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 |

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| | | | |
|---|---|---|---|
| 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 | |

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| | | |
|---|---|---|
| Do you and your child read together daily? | Yes | No |
| Does your child typically watch MORE than 1 hour of TV/Computer/Video games, etc. daily? | Yes | No |
| 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 |

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| | | |
|---|---|---|
| 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 |

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

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Who provides day time care for your child?

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Is your child on any medications or supplements, including fluoride or vitamins? If so, please list below:

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Do you have any international travel plans prior to your child's fourth birthday? If so, when and where?

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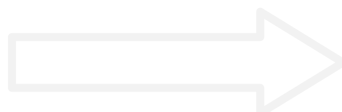
CONTINUES ON OTHER SIDE



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PEDIATRICS

# Well Child Check: 3 Year Visit

**Risk Assessment for Tuberculosis Exposure**:

| Question | No | Yes |
|---|---|---|
| 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 OTHER SIDE