



Well Child Check: 4 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.

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|---|-----|----|
| Can your child hop on one foot? | Yes | No |
| Can your child dress himself? | Yes | No |
| Can your child draw a person with 3 body parts? | Yes | No |
| Can your child use scissors? | Yes | No |
| Does your child know at least 4 colors? | Yes | No |
| Does your child recognize most letters? | Yes | No |
| Does your child know his first and last name? | Yes | No |
| Does your child play cooperatively with other kids? | Yes | No |
| Does your child engage in make-believe play? | Yes | No |
| Can strangers understand your child's speech? | Yes | No |

How many ounces of milk does your child drink in 24 hours? _____ oz. Whole 2% 1%

Does your child usually drink more than 4 oz. of juice or sweetened drinks daily? No Yes

Does your child eat meat (such as fish, chicken, beef, or pork)? Yes No

Does your child typically watch MORE than 1 hour of TV/Computer/Video games, etc. daily? No Yes

Is your child toilet trained during the day? Yes No Partially

Do you usually protect your child with sunscreen/hats/other measures when outdoors? Yes No

Does your child wear a helmet if he is riding a tricycle or bike? Yes No Sometimes

Do you help your child brush his/her teeth twice a day? Yes No

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

Any changes in your family since the last visit? Yes No

Are there guns at your home, or any home your child regularly visits? No Yes

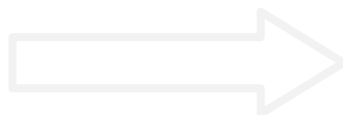
Does your child have access to a pool that does not have a locked gate? No Yes

Do you have any other safety concerns at your home? If so, please describe:

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:

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

Risk Assessment for Tuberculosis Exposure:

Has a family member or contact had tuberculosis disease? Yes No

Since your child’s last well check has a family member or contact had a positive tuberculosis test? Yes No

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

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

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? Yes No

