OBERLIN ROAD PEDIATRICS

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.

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:

_____

Feb 2019

CONTINUES ON OTHER SIDE

OBERLIN ROAD PEDIATRICS

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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

_____

_____

_____

_____

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CONTINUES ON OTHER SIDE