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

Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
How many ounces of milk does your child drink in 24 hours? _____ oz.	Whole	Low fat	Nonfat
Is your child completely weaned from the bottle?	Yes	No	Unsure
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	Unsure
Do you and your child read together daily?	Yes	No	Unsure
Does your child typically watch MORE than 2 hours of TV/Computer/Video games, etc. daily?	No	Yes	Unsure
Is your child toilet trained during the daytime?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/ other measures when outdoors?	Yes	No	Unsure
Does your child wear a helmet is he/she is riding a tricycle?	Yes	No	Unsure
Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	Unsure
Does your tap water contain fluoride?	Yes	No	Unsure
Are there guns at your home, or any home your child regularly visits?	No	Yes	Unsure
Does your child have access to a pool that does not have a locked gate?	No	Yes	Unsure

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:

_____

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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Well Child Check: 3 Year Visit

Risk Assessment for Tuberculosis Exposure/Infection:

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

_____

_____

CONTINUES ON OTHER SIDE