Stanford Children's Health

Patient Name/Date of Birth:_____

Well Child Check: 3 year visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office?	No	Yes	
Has your child had any reactions to vaccinations in the past?	No	Yes	

Development:

Can your child kick a ball? Jump off the ground?	Yes	No	
Can your child pedal a tricycle?	Yes	No	Unsure
Does your child speak in sentences (3 words or more)?	Yes	No	
Does your child use plurals (cars, balls, etc)?	Yes	No	
Does your child understand concepts such as cold, tired, hungry?	Yes	No	
Is your child's speech at least 50% understandable to most people?	Yes	No	
Does your child know his/her name, age and gender?	Yes	No	
Does your child start to say the ABC's?		Yes	No
Does your child identify several colors?	Yes	No	
Can your child help with getting him/herself dressed, brushing teeth?	Yes	No	
Does your child alternate feet when walking up the stairs?	Yes	No	
Can your child copy a circle and a cross (+)?	Yes	No	
Is your child potty trained?	Yes	No	
Do you and your child read together daily?	Yes	No	
Do you have concerns about how your child sees?	No	Yes	
Do you have concerns about how your child hears?	No	Yes	
Do you have concerns about how your child speaks?	No	Yes	

Dental Health:

Do you help your child brush and floss his/her teeth daily?	Yes	No	
Does your child have a dentist?	Yes	No	
Does your child's primary water source contain fluoride?	Yes	No	Unsure
If no, do you give your child a fluoride supplement?	Yes	No	N/A

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV/play video games or use a tablet or smart phone more than 2 hours per day?	No	Yes	

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Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A
If your home has more than one floor, do you have safety guards on the windows?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always stay with your child when she/he is in the bathtub?	Yes	No	
Do you and your child spend time near water (pool, river or lake)?	No	Yes	
If so, is your child always safely supervised?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your child in a forward-facing car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your child?	Yes	No	
Do you always check for children before backing your car out?	Yes	No	
Does your child spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your child wear a helmet when riding a tricycle, bike or scooter?	Yes	No	N/A
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	
Does your child spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes	
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes	
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes	
Does your child take any imported remedies or supplements?	No	Yes	

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Tuberculosis Screening:

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)? No Yes Unsure

Was your child born in a high risk country (countries ***other than*** the US, Canada, Australia, New Zealand or Western Europe? 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 US, Canada, Australia, New Zealand or Western Europe) No Yes

Sleep:

How many hours does your child sleep at night? ____ hours

How many hours does your child nap throughout the day? ____ hours

Nutrition/Physical Activity:

What type of milk do you give your child? (circle one) [Whole] [2%] [Nonfat] [Other]

How many ounces of milk does your child drink per day? ____ oz

How much juice does your child drink in 24 hours? ____ oz

Is your child eating fruits and vegetables at least two times per day? Yes No

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes No

Does your child eat high fat foods such as fried foods, chips, ice cream or pizza more than once per week? No Yes

Does your child drink soda, sports drinks, energy drinks or other sweetened drinks more than once per week? No Yes

Does your child eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)? Yes No

Do you ever struggle to put food on the table? No Yes

Does your child play actively most days of the week? Yes No

Do you have any concerns about your child's weight or feeding? No Yes

Elimination:

Does your child have bowel movements on a regular basis with a normal (soft) consistency? Yes No

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Please list any medications or supplements your child is taking: _____

_____

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues: _____

_____

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

Signature: _____ Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver.5-7-15