UW Medicine
UW NEIGHBORHOOD CLINICS

3 Year Old Well Child Visit

Child's Name________________________________Child's Age __________Date:______________

Person completing the form__________________________Relationship to the patient_____________________

Has your child had any illnesses, hospitalizations or surgeries since last visit here? (YES) (NO)

Nutrition:	Yes	No
Is your child drinking low-fat milk, limited to no more than 2-3 cups per day?	( )	( )
Is juice /sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child take a supplement that contains vitamin D regularly?	( )	( )
On average, do you eat fast food one or more times per week?	( )	( )

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illnesses, moves, death, separation?	( )	( )

Preventative Health/Risk Factors:	Yes	No
Is screen time (TV time/videos/video games/computer/tablet/phone) limited to less than 2 hours a day?	( )	( )
Does your child always ride in a car seat, in the back seat?	( )	( )
Do you, anyone who cares for your child or anyone in the home smoke?		
Does your child wear a helmet when riding a tricycle, bicycle, etc?	( )	( )
Are there any guns in the home? If yes, are they always empty and locked?	( )	( )
Are there smoke detectors and fire extinguishers in the home and are they checked yearly?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB) or is at risk for TB (visited Africa, Latin American, Caribbean country, been homeless or jailed, IV drug user, HIV positive)?	( )	( )
Does your child have at least 1 hour of active play per day?	( )	( )

Oral Health:	Yes	No
Does your child see a dentist twice a year and brush teeth daily?	( )	( )

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well without snoring?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are there any guns in the home? If yes, are they always empty and locked?	( )	( )
Are you interested in enrolling your child in Head Start/preschool? If yes, do you need assistance with this?	( )	( )

Developmental Surveillance:	Yes	No
Social-Emotional:		
Can help feed and/or dress self?	( )	( )

Pretend play?		
Communicative:		
Puts together 2-3 sentences?	( )	( )
Usually understandable?	( )	( )
Names a friend?	( )	( )
Cognitive:		
Names object?	( )	( )
Knows if boy or girl?	( )	( )
Physical development:		
Build tower 6-8 blocks?	( )	( )
Stands on 1 foot?	( )	( )
Throws ball overhand?	( )	( )
Walks upstairs alternating feet?	( )	( )
Copies circles?	( )	( )
Draws person (2 body part)?	( )	( )
Toilet trained during daytime	( )	( )