

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?	<input type="checkbox"/>	<input type="checkbox"/>
Is juice or sugary drinks limited to 0-1 servings per day?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child eat a variety of fruits/vegetables/dairy/meat?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child regularly take a supplement that contains vitamin D?	<input type="checkbox"/>	<input type="checkbox"/>
On average, does your child eat fast food one or more times per week?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

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

Oral Health:	Yes	No
Does your child see a dentist twice a year and brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep well, without snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in enrolling your child in Head Start, or preschool?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, do you need assistance to find a suitable program?	<input type="checkbox"/>	<input type="checkbox"/>

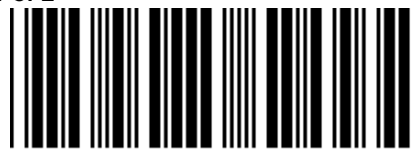
PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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Developmental Surveillance:

Social/Emotional Development:	Yes	No
Can help feed and dress self?	<input type="checkbox"/>	<input type="checkbox"/>
Pretend play?	<input type="checkbox"/>	<input type="checkbox"/>

Communicative Development:	Yes	No
Puts together 2-3 sentences?	<input type="checkbox"/>	<input type="checkbox"/>
Usually understandable?	<input type="checkbox"/>	<input type="checkbox"/>
Names a friend?	<input type="checkbox"/>	<input type="checkbox"/>

Cognitive Development:	Yes	No
Names object?	<input type="checkbox"/>	<input type="checkbox"/>
Knows if boy or girl?	<input type="checkbox"/>	<input type="checkbox"/>

Physical Development:	Yes	No
Build tower 6-8 blocks?	<input type="checkbox"/>	<input type="checkbox"/>
Stands on 1 foot?	<input type="checkbox"/>	<input type="checkbox"/>
Throws ball overhand?	<input type="checkbox"/>	<input type="checkbox"/>
Walks upstairs alternating feet?	<input type="checkbox"/>	<input type="checkbox"/>
Copies circles?	<input type="checkbox"/>	<input type="checkbox"/>
Draws person (2 body parts)?	<input type="checkbox"/>	<input type="checkbox"/>
Toilet-trained during daytime?	<input type="checkbox"/>	<input type="checkbox"/>

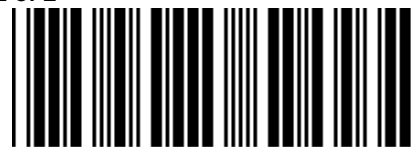
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