

Well Child Care 3 yrs

Name :

DOB:

Date:

Do you have any concerns today ? No Yes _____

Nutrition/Review of systems	yes	no	Review of systems/symptoms	yes	no
Appetite good ?			Any Vision Problems?		
Eats carbs, vegetables ,fruits, meat, fish ,fast foods, candy? (circle)			Any hearing problems?		
Drinks Milk? _____ oz/day			Any breathing problems ?		
Drinks soda ? _____ oz/day			Any heart problems ?		
Drinks juice ? _____ oz/day			Any skin problems?		
Bowel movements normal ?			Any sleep concerns?		
Stool hard ? Cries with bowel movements ?			Any past bad reactions from immunizations ?		
Urination normal?			Any lead poisoning risks ?		
Immunizations up to date?			Any TB Exposure?		
Oral Health risk Assessment :					
Mother/primary caregiver had active tooth decay in past 12 mo?			Mother or primary caregiver has a dentist ?		
Frequent snacking ?			Bottle/ sippy cup use with fluids other than water ?		
Special health care needs?			Medicaid eligible ?		
Child has a dentist ?			Water supply <input type="checkbox"/> city <input type="checkbox"/> well <input type="checkbox"/> drink bottled water		
Has teeth brushed twice daily?			Any dental Concerns?		
Developmental Questions : Can your child					
Ask questions " what's that" & " why " ?			Easily understood by most adults?		
Answer the question, "Are you a boy or girl"?			Name at least one color ?		
Name at least one picture from animal books?			Talk in 3-word sentences most of the time ?		
Copy a circle?			Enjoy sitting together for at least 5 min for story time?		
Walk upstairs with alternating feet?			Help put things away?		
Pedal a tricycle ?			Throw a ball overhand from a distance of 5 feet?		
Safety/anticipatory guidance issues:					
Family violence & substance abuse? circle			Car seat front facing?		
Exposed to passive smoking?			Fall, Fire and Burn precaution in place?		
Home swimming pool ?			Medication, personal hygiene products, alcohol, cleaning supplies, trash containers out of reach?		
Family history :					
High cholesterol ,High Triglycerides			Obesity		
Diabetes			Early Heart disease ,High Blood pressure		

Anticipatory guidance: discussed and / or handout given

Family support : show affection manage anger reinforce appropriate behavior reinforce limits find time for yourself . **Encouraging literacy**

activities: Read, sing, play talk about pictures in books encourage child to talk .

Playing with peers: encourage appropriate play fantasy play non-confrontational play with peers. **Promoting physical activities:** family exercise ,activities.

Limit screen time -max 1-2 hrs/ day no TV in bedroom.

Diet & Nutrition: food variety including carbs, protein, fat ,fibers Limit fast foods and eating out Limit milk intake to 16 oz/day or less for children 1-5 yrs. Limit juice and other sweetened drinks 4-6 oz/day wean from bottle and drink from non-covered cup (avoid sippy cups).

Safety: car safety seat supervise play near streets, cars safety near windows.

For providers : fasting lipid age 2-10 if any of above risk factors. **2-5 yrs** Wt gain 4.5 lbs/yr ,Ht gain 2.5 inch/yr. **Visual acuity :** 20/30 by 3yr, 20/20 by 4 yr. All primary teeth by 3 yr. Bowel & bladder control average by 30 mo but strong individual and cultural variation. Bedwetting normal up to age 4 (girls),age 5 (boys).

Signature of parent/guardian:

Provider signature: