Medical Record Number

Patient Name

Patient Label

Well Child Check: 4 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 throw a ball? Hop on one foot?	Yes	No
Can your child walk on his/her tip toes?	Yes	No
Does your child speak in complex sentences?	Yes	No
Does your child tell stories and sing songs?	Yes	No
Does your child engage in make-believe play, or use his/her imagination in another way?	Yes	No
Is your child's speech clear (little or no difficulty understanding what your child says)?	Yes	No
Does your child know some colors and letters?	Yes	No
Can your child count to 10?	Yes	No
Does your child know his/her full name?	Yes	No
Can your child cut (with safety scissors) and paste?	Yes	No
Does your child alternate feet when walking up and down stairs?	Yes	No
Does your child enjoy playing with several children, have friends?	Yes	No
Do you and your child read together daily?	Yes	No
Do you have any concerns about how your child hears or speaks?	No	Yes
Do you have any concerns about how your child sees?	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
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 (a swimming pool, river or lake)?	No	Yes	
If so, is your child always safely supervised,	Yes	No	N/A
Knows or is learning how to swim?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your child in a 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 bike, skateboard 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	

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No Yes
This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate ***for one month or more***? (Countries other than those listed above) No Yes

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No Yes Unsure

Is your child immunosuppressed (currently or planned)? No Yes
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (heart attack, stroke, angioplasty, angina or bypass surgery)? No Yes

If yes, who? _____ _____at what age? _____

Do either of the child's parents have a cholesterol of 240 or higher? No Yes

If yes, who? _____How high? (before treatment) _____

Sleep:

How many hours does your child sleep at night? ____ 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 junk foods such as chips, fries, ice cream or fast food more than twice 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 have trouble affording to buy food for your family?	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

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?

_____

Parent or Guardian 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:

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