

Your Child's Name: _____

Three Year Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out **BOTH SIDES**

Does your child pedal a tricycle?	Yes	No	Unsure
Can your child throw a ball overhand?	Yes	No	Unsure
Can your child get dressed with your help (or on own)?	Yes	No	Unsure
Can your child copy a circle?	Yes	No	Unsure
Are at least three-fourths of the words your child uses understandable to most people?	Yes	No	Unsure
Does your child know his or her name, age and sex?	Yes	No	Unsure
Does your child join other children in play?	Yes	No	Unsure
Does your child count to three or more?	Yes	No	Unsure
Does your child ask questions?	Yes	No	Unsure

How many ounces of milk does your child drink in 24 hours? _____oz ; whole lowfat nonfat

How many ounces of juice does your child drink in 24 hours? _____oz

Is your child completely weaned from the bottle? Yes No

Does your child eat meat (such as fish, chicken, beef or pork)? Yes No

Is your child toilet trained during the daytime? Yes No Partially

Do you and your child read together daily? Yes No Unsure

On a typical day, does your child have less than 2 hrs of screen time?
(TV, videogames, computer, etc) Yes No Unsure

Do you usually use sunscreen for your child when outdoors? Yes No Unsure

Does your child wear a helmet if he/she is riding a tricycle? Yes No Sometimes

Has your child seen a dentist regularly? Yes No Unsure

Are there guns at your home, or any home your child regularly visits? Yes No Unsure

Does your child have access to a home pool? Yes No Unsure

Do you have any other safety concerns at your home? Yes No Unsure

If so, please describe _____

PLEASE TURN OVER

Your Child's Name: _____

Who provides daytime care for your child? _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No

Has a family member had a positive tuberculin skin test? Yes No

Was your child born in a high-risk country?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes No

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 United States, Canada,
Australia, New Zealand, or western European countries) Yes No

Do you have any concerns about your child's development, or any
other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?