**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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Have you turned your water temperature down to low-warm (less than 120 degrees)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>If your home has more than one floor, do you have safety guards on the windows?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Does your home have cleaning supplies/medicines/matches locked away?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you always stay with your child when she/he is in the bathtub?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you and your child spend time near water (a swimming pool, river or lake)?</td>
<td>No</td>
<td>Yes</td>
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<td>If so, is your child always safely supervised,</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Knows or is learning how to swim?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Do you use sunscreen when your child is outdoors?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you always place your child in a car seat in the back seat?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Is your car seat the right one for the age and size of your child?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you always check for children before backing your car out?</td>
<td>Yes</td>
<td>No</td>
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<td>Does your child spend time in a home where a gun is kept?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<td>If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Does your child wear a helmet when riding a bike, skateboard or scooter?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Has your child ever witnessed or been a victim of abuse or violence?</td>
<td>No</td>
<td>Yes</td>
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<td>Does your child spend time with anyone who smokes?</td>
<td>No</td>
<td>Yes</td>
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**Risk Assessment for Lead Exposure:**

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<td>Does your child live in or regularly visit a house or child care facility built before 1950?</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>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)?</td>
<td>No</td>
<td>Yes</td>
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<td>Does your child have a sibling or playmate who has or did have lead poisoning?</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Does your child take any imported remedies or supplements?</td>
<td>No</td>
<td>Yes</td>
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**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: __________________

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<th>Clinic Use Only</th>
<th>Counselled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
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PCP’s Signature  Print Name:  Date:  

Patient Declined the SHA

Ver. 12-12-17