3 Year Visit

NAME DATE

Are you concerned about your child's….

1.Nutrition or eating habits?	YES	NO
2. Eyes or vision?	YES	NO
3. Recurrent ear infections or hearing?	YES	NO
4. Breathing or congestion?	YES	NO
5. Diarrhea, constipation or toileting?	YES	NO
6. Birthmarks, skin rashes or new lesions?	YES	NO
7. Behavior?	YES	NO
8. Food or drug allergies?	YES	

Does your child…..

1. Have self care skills? (self feeding and some self dressing)	YES	NO
2. Enjoy interactive play?	YES	NO
3. Play imaginatively and increasingly elaborate?	YES	NO
4. Converse with 2 or 3 sentences spoken together?	YES	NO
5. Have speech understandable 75% of the time?	YES	NO
6. Identify self as a boy or a girl, correctly?	YES	NO
7. Know age?	YES	NO
8. Know the name of and the use for a cup, ball, spoon and crayon?	YES	NO
9. Build a tower with 6-8 cubes?	YES	NO
10. Throw a ball overhand?	YES	NO
11. Walk up stairs alternating feet?	YES	NO
12 Balance on 1 foot for 1 second?	YES	NO
13. Ride a tricycle?	YES	NO
14. Copies a circle?	YES	NO
15. Draws a person wit 2 body parts? (head and one other)	YES	NO
16. Use the toilet for stool and urine?	YES	NO
17. Ride in a car seat?	YES	NO
18. Have TV and screen time restrictions to < 2 hours per day?	YES	NO
19. Restricted from access to all firearms?	YES	NO

Tuberculosis Screen (TB)

1. Has a family member or contact had tuberculosis disease?	YES	NO
2. Has a family member had a positive TB test?	YES	NO
3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe?	YES	NO
4. Has your child traveled to a high risk country for more than 1 week?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent remodeling or renovation? (with in 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

Do you have any other concerns you wish to discuss? YES NO

Office use only

WT HT HC BP BMI%tile