3 YEAR OLD

NAME _____
DATE _____

pediatrics NORTHWEST PS Mary Bridge Children's

www.pedsnw.net

MEDICAL HISTORY

Select Has your child had any reactions to medications or immunizations?
Select Does your child take any medications (daily or as needed)?
Select Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
Select Are there any major illnesses in the family? Which ones? _____
Select Are there any major changes or stresses in the family (moves, deaths, separation, etc)?
Select Does you child attend day care or preschool? Where? _____
Select Has your child ever been diagnosed with an immunodeficiency?
Select Has your child had any illnesses, hospitalizations, or surgeries that we are not already aware of?

NUTRITION

Select Does your child get at least 4-5 servings of fruits/vegetables each day?
Select Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
Select Does your child drink anything other than milk and water?
_____ How many times per week does your child eat fast food?

PREVENTIVE HEALTH

Select Has your child seen a dentist in the past 6 months?
Select Does your child always ride in a car seat and in the backseat?
Select Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Select Have those alarms been checked in the past 12 months?
Select If you own firearms, are they always locked up?
Select Does your child live with anyone who smokes?
Select Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV positive)?
_____ How many hours of "screen time" (TV, movies, video games etc) is your child around per day?

REVIEW OF SYSTEMS *(Does your child have any **CURRENT** problems with the following?)*

Select headaches, fainting, dizziness, any loss of consciousness, or history of concussion
Select eyes (crossing, poor vision, etc)
Select ears, hearing, nosebleeds, or snoring disrupting sleep
Select coughing, breathing, shortness of breath, wheezing, limited endurance or chest pain
Select frequent stomachaches, vomiting, diarrhea, constipation or any blood in the stools
Select urination (change in frequency, or blood in the urine)
Select coordination or extremities (feet, legs, arms, hands)
Select Has your child received blood, plasma, respigam, or gammaglobulin?

DEVELOPMENT (please check the things that your child is currently doing)

Gross motor	☐ kicks a ball ☐ jumps ☐ hops on one foot ☐ throws a ball
Fine motor	☐ stacks blocks ☐ scribbles ☐ draws circle and cross ☐ uses scissors
Language	☐ speech understandable ☐ names 3 colors ☐ starting to count

CONCERNS

Select Do you have any special concerns today?

Thanks for filling out this form.