NOVANT HEALTH

Appt Date________________ 3 year Check Up

Patient Name______________________________________DOB__________________________
Name of person filling out form ________________________Phone number________________

Nutrition:

What does your child drink? (circle all that apply) Whole Milk Soy Milk Water Juice Other_______________
How many ounces of milk does your child drink per day? ____
How many ounces of juice does your child drink per day?____
How many ounces of water does your child drink per day?____
Does your child eat a variety of meats, fruits, and vegetables each day?____________________________________

Bowel/Bladder:

Any concerns about your child's voiding or stooling?____

Sleep:

How many hours does your child sleep at night? ____
How many naps does your child take during the day? _______________ How long are the naps? ________________

Hearing/ Vision:

Any concerns about your child's hearing or vision?____

Social hx:

Does your child attend daycare, preschool, or stay at home?______________________________________
How much screen time does your child get each day? ____

Development: Please check the developmental milestones that you notice your child accomplishing:

___Undresses self and some dressing
___Copies a circle
___Uses five- to eight- word sentences
___75% of speech is understandable by a stranger
___Walks up stairs alternating feet
___Balances on one foot for one second
___Pedals a tricycle or bike
___Engages in group play

Advice and Guidance for Parents: *(please check off as you read)*

___Wear SPF 30 or greater for sun exposure
___Read to your child at least once a day
___Smoke Exposure: Minimize your child's exposure to cigarette smoke
___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____
___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___
___Continue to brush your child's teeth every night, twice a day if possible (this is "non-negotiable"). This is a good time to begin taking your child to the dentist if you have not done so already.
___Many children are not completely potty trained yet. Continue to make this a positive experience for your child, and don't put too much pressure on him/her. (Many children are not trained at night until age 4 or 5)
___Limit screen time to no more than 2 hours per day. You should not put a TV in your child's room.
___ Nutrition: Skim milk is recommended (limit to 12 to 16 oz daily). No more than 6 oz. sugar drinks daily.
___ Behavior: "Catch" your child being good. Continue using timeout for major offenses. (3 year olds ask a lot of questions!)
___ Sleep: Your child should have 12 hours of sleep per day. Most three year olds will still take one nap daily, but may drop this nap as he/she gets closer to four years old.
(for podcasts on Sleep and Behavior, go to www.shotshurtless.com)

PEDS Response Form

Provider

Child's Name ______________________ *Parent's Name* ______________________

Child's Birthday ______________________ *Child's Age* ______________ *Today's Date* ______________

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.

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