Appt Date_____ 4 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 following developmental milestones that you notice your child accomplishing:

___Balances on one foot
___Catches a ball
___Tells a simple story
___Speech is 100% understandable by a stranger
___Copies a circle and a cross
___Draws a person with 3 parts
___Dresses self, including buttons
___Engages in imaginative 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
___After your child has brushed his/her teeth, you should continue to brush them as well. Be sure your child brushes his/her teeth at least twice a day and flosses.
___Regular dental exams are important for maintaining oral health.
___Many 4-year olds still wet the bed at night. Limit the amount of fluids your child drinks before bedtime, and take your child to the bathroom when you are getting ready for bed to help with this.
___Limit screen time to no more than 2 hours per day. You should not put a TV in your child's room.
___Structured learning experiences and other opportunities to socialize with other children are a good way to prepare your child for kindergarten.
___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___
___ Nutrition: Skim milk is recommended (limit to 12 to 16 oz daily). No more than 6 to 8 oz. sugar drinks daily.
___ Behavior: "Catch" your child being good. Continue timeouts for major offenses and take things away.
___ Sleep: Your child should have 11½ hours of sleep per day. Most four-year olds no longer take naps, but quiet time during the day is encouraged.
(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.