UW Medicine
UW NEIGHBORHOOD CLINICS

4 Year Old Well Child Visit

Child's Name _____ Child's Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	**Yes**	**No**
Does she/he eat well-balanced diet, including fruits, vegetables, milk, and vitamins?	( )	( )
Does your child see a dentist twice a year?	( )	( )
Do you help your child brush her/his teeth 2 times daily?	( )	( )
Do you help your child floss her/his teeth once daily?	( )	( )

Elimination	**Yes**	**No**
Is your child stooling comfortably?	( )	( )
Is she/he toilet trained during the day?	( )	( )

Sleep	**Yes**	**No**
Is your child sleeping well?	( )	( )

Social Screening	**Yes**	**No**
What are your current child-care arrangements?		
Does your child have a car seat or booster seat if outgrew car seat (40-65 lbs, depending on the seat)?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Do you read with your child 3 or more times per week?	( )	( )
Does your child get along well with other children?	( )	( )
Are you pleased with her/his behavior overall?	( )	( )
Enrolled (or planning to enroll) in preschool?	( )	( )
Is screen time (TV, video games, computer) limited to <2 hours per day?	( )	( )
Tuberculosis (TB) risk?		
1. Contact with person who has tuberculosis	( )	( )
2. Your child is immuno-suppressed (HIV, cancer, chronic steroids)	( )	( )
3. Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	( )	( )
4. Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	( )	( )

Developmental Screening	**Yes**	**No**
Seems to hear well?	( )	( )
Speech is fully understandable?	( )	( )
Hops on 1 foot?	( )	( )
Knows colors?	( )	( )
Can count to 5 or higher?	( )	( )
Plays games involving taking turns & following rules (eg, hide & seek)?	( )	( )
Can put on pants, shirt, dress, or socks without help (except buttons, etc)?	( )	( )
Can say full name?	( )	( )
Can copy a picture of a plus (+)? (try on the back of this sheet)	( )	( )

Has your child had any significant illness since the last time we saw you? If yes, please describe:

_____

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

_____

Current concerns not listed above:

_____

_____