4 Year Well Child Check Name_____

Allergies_____Current Meds_____

Is your child healthy?	**Yes**	**No**_____
Has your child had any recent illness?	No	Yes_____
Has you child had any recent injuries?	No	Yes_____
Does your child take a vitamin or supplement?	Yes	No
Is there Fluoride in your drinking water? (city water=yes)	**Yes**	**No**
Does your family eat a well-balanced diet?	Yes	No
Does your child stool at least once daily?	Yes	No_____
Is your child dry at night?	Yes	No_____
Has there been any recent change to your family structure?	**No**	**Yes**_____
Does anyone in your household smoke?	No	Yes
Is your child in childcare?	No	Yes_____
Are you familiar with the 5-3-2-1-0 Healthy Lifestyles?	*Yes*	*No*
Do you have concerns about behavior or discipline?	*No*	*Yes*_____
Does your child see a dentist?	*Yes*	*No*
Are there any unsecured firearms in the house?	*No*	*Yes*_____
Does your child have more than 2 hrs of screen time/day?	*No*	*Yes*
Is your child in a car seat or booster seat?	*Yes*	*No*

*Do you have any other concerns?*_____

_____

_____

Development (Do not complete if given the Ages and Stages Questionnaire)

Does your child sing a song?	Yes	No
Does your child draw a person with 3 parts?	Yes	No
Is your child aware that of his/her gender?	Yes	No
Does you child know the difference between fantasy and reality?	Yes	No
Does your child speak in sentences?	Yes	No
Does your child know his/her first and last name?	Yes	No
Does your child know 3-4 colors?	Yes	No
Does your child talk about his/her day?	Yes	No
Does your child button his/her clothes?	Yes	No
Does your child build a tower with 10 blocks?	Yes	No
Does your child hop or jump on one foot?	Yes	No
Does your child ride a bike with training wheels?	Yes	No
Does your child throw a ball overhead?	Yes	No
Can your child put toys away?	Yes	No