Pediatrics Southwest

HEALTH UPDATE SHEET
3 YEARS TO 5 YEARS
MARK D. TOWNS, M.D.

Child's Name: _____

Date of Birth: _____

INSTRUCTIONS:

In order to give your child the best care and to help identify your concerns, please answer the following questions. Find the column for your baby's age and fill in today's date. Answer each question by circling yes or no in the appropriate column. If you cannot answer the question, just move to the next one.

	3 YRS	4 YRS	5 YRS
CHILD'S CURRENT AGE ⇒			
TODAY'S DATE ⇒			
SINCE HIS/HER LAST WELL-CHILD CHECKUP HERE, HAS YOUR CHILD…			
1. Been seen by a doctor, clinic or other specialist besides at this office?	Yes No	Yes No	Yes No
2. Had any bad reactions to shots, food or medicine?	Yes No	Yes No	Yes No
3. Experienced any important changes for the family - moves, job loss, serious illness, family problems, new baby, etc.?	Yes No	Yes No	Yes No
SINCE HIS/HER LAST WELL-CHILD CHECKUP, DOES YOUR CHILD…			
4. Seem to have trouble hearing?	Yes No	Yes No	Yes No
5. Seem to have trouble seeing or have eyes that turn in or out?	Yes No	Yes No	Yes No
6. Have ear trouble or infections?	Yes No	Yes No	Yes No
7. Have frequent colds, runny nose, sore throat or cough?	Yes No	Yes No	Yes No
8. Usually breathe with his/her mouth open or snore?	Yes No	Yes No	Yes No
9. Ever wheeze or have trouble breathing?	Yes No	Yes No	Yes No
10. Have problems with stomach or bowels?	Yes No	Yes No	Yes No
11. Have urine infections or problems?	Yes No	Yes No	Yes No
12. Have seizures, convulsions, or blackouts?	Yes No	Yes No	Yes No
13. Complain of frequent aches and pains?	Yes No	Yes No	Yes No
14. Seem unusually tired?	Yes No	Yes No	Yes No
15. Go to a dentist regularly?	No Yes	No Yes	No Yes
16. Seem generally happy and pleasant to be with?	No Yes	No Yes	No Yes
17. Get along well with others?	No Yes	No Yes	No Yes

Please continue on the other side

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CHILD'S CURRENT AGE →			
TODAY'S DATE →			
18. Does he/she eat a variety of foods including representatives from each of the following:			
Rice, cereal, breads, or pasta?	No Yes	No Yes	No Yes
Fruits and vegetables?	No Yes	No Yes	No Yes
Milk, cheese, yogurt, and meats?	No Yes	No Yes	No Yes
19. Use a seatbelt or appropriate carseat when riding in the car?	No Yes	No Yes	No Yes
20. Have you child-proofed the house? (poison control number by the phone, stair gates, smoke alarms, plug covers, cabinet and drawer latches, guns locked and stored away from ammunition, water temperature <120 degrees, etc.)	No Yes	No Yes	No Yes
21. Have you started to teach your child about safety issues? (stranger awareness, calling 911, stop-drop-roll, bicycle helmets, pool safety, etc)	No Yes	No Yes	No Yes
22. Does your child do these things yet?			
Jump, kick a ball?	No Yes	No Yes	No Yes
Know his/her name and age?	No Yes	No Yes	No Yes
Speak clearly so strangers can understand?		No Yes	No Yes
Ask what, why, where questions?		Yes No	Yes No
Use the bathroom by himself/herself?		No Yes	No Yes
Know at least 3 colors?		No Yes	No Yes
Play games, taking turns, following rules?		No Yes	No Yes
Draw "people"? At least head, eyes and mouth?		No Yes	No Yes
Count up to 10?			No Yes
Dress himself/herself (except tie shoes)?			No Yes
Seems ready for kindergarten?			No Yes

23. Estimate how many hours a week your child is in daycare, preschool or with a sitter? _____

23. How many hours a day does your child watch television or play video games? _____

24. Are you concerned about your child's behavior in any way? _____

25. Which of these have been problems? (circle)

EASILY UPSET	WON'T MIND	SPEECH PROBLEMS
CRIES TOO MUCH	BAD TEMPER	TROUBLE SLEEPING
HIGH STRUNG OR NERVOUS	FIGHTS TOO MUCH	STEALING
TOO SHY	TROUBLE TOILET TRAINING	LYING