4 Year Visit

NAME DATE

Are you concerned about your child's….

1. Eating habits, nutrition?	YES	NO
2. Bowel habits?	YES	NO
3. Urinary control or bed wetting?	YES	NO
4.Skin changes or new lesions?	YES	NO
5. Behvior, in general?	YES	NO
6. Sleep habits?	YES	NO
7. Food or drug allergies?	YES	NO

Does your child…..	YES	NO
1. Act withdrawn or non social?	YES	NO
2.Show signs of hostility or aggrs: ressiveness?	YES	NO
3. Act defiant?	YES	NO

4. Listen to stories?	YES	NO
5. Engage in fantasy play?	YES	NO
6. Know and give first and last name?	YES	NO
7. Sing a song from memory?	YES	NO
8. Know what to do if cold, tired or hungry?	YES	NO
9. Have speech understandable 90% of the time?	YES	NO
10. Name 4 colors	YES	NO
11. Know own gender and that of others?	YES	NO
12. Draw a person with 3 parts?	YES	NO
13. Hop on one foot?	YES	NO
14. Balance on 1 foot for 2 seconds?	YES	NO
15. Build a tower of 8 blocks?	YES	NO
16. Copy a cross? (+)	YES	NO
17. Pour, cut and mash own food?	YES	NO
18. Brush own teeth?	YES	NO
19. Dress self, including buttons?	YES	NO

Tuberculosis Screen (TB)

1. Has a family member or contact had tuberculosis disease?	YES	NO
2. Has a family member had a positive TB test?	YES	NO
3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe?	YES	NO
4. Has your child traveled to a high risk country for more than 1 week?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent remodeling or renovation? (with in 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

Do you have any other concerns you wish to discuss? YES NO

Office use only

WT HT HC BP BMI%tile