MUNDELEIN PEDIATRICS

3 Year Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
   (____) hours from naps during the day
2. Good eating habits: Yes/No Concerns: _____
   Milk: (____) ounces of milk daily
   Fruit juice: (____) ounces of fruit juice daily
3. Urinating well: Yes/No Concerns: _____
4. Potty training in process Yes/No Concerns: _____
5. Normal bowel movements: Yes/No Concerns: _____
6. Takes Vitamins: Yes/No Product Name: _____
7. Emergency room visits: Yes/No
8. Illness since last visit: _____
9. Developmentally: Puts on clothing, makes believe play, knows full name, puts 3 words together, vocab of 20 words or more, comprehends cold, tired and hungry, walks up steps, kicks ball forward, colors with crayons, throws ball overhead, recognizes colors (3 out of 4), uses plurals, plays interactively with other children

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Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Firearms at home: Yes/No If yes, are safety precautions taken: Yes/No
4. Television/video game time: Yes/No Hours per day: _____
5. Rides in a car seat in the back seat: Yes/No
6. Daycare: None/Relative/Center/Babysitter
7. Primary care taker: Mom/Dad/Grandparents
8. Household composition:
   Adult(Names/Ages): _____

   Children(Names/Ages): _____
9. New health problems in parents or sibling: _____
10. Dental visits Yes/No
11. Past vaccine reactions: Yes/No
12. Sibling rivalry Yes/No

Do you have any other concerns you wish to discuss? Yes/No

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