Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

4 Year Old Parent Observations

Are there any concerns you would like to discuss today?_____

_____

Diet/Sleep:

Any concerns about diet or weight gain/growth?	Yes	No
Does your child eat well (i.e. has consistent appetite, not too picky)?	Yes	No

What does your child drink?_____

If picky, what does your child dislike? _____

Any concerns about voiding or stooling? (i.e. constipation, diarrhea)	Yes	No
Is your child potty trained: (check all that apply) ☐ Day ☐ Night ☐ Urine ☐ Stool		
Does your child have any problems with sleep?	Yes	No

Development:

Do you read to your child every day?	Yes	No
How much screen time (TV/tablet/phone) does your child have per day? _____		
Do you have any concerns about your child's hearing or vision?	Yes	No
Any concerns about your child's development?	Yes	No

Does your child: (please check all that apply)

☐ draw a circle	☐ catch bounced ball	☐ know first/last name
☐ stack 8+ blocks	☐ count to 5-10	☐ know shapes/colors
☐ hop	☐ use complete sentences	☐ pretend play
☐ stand on one foot	☐ speech is 100% understandable	☐ participate in cooperative play

Social/Behavior:

If parent(s) work, who cares for your child? _____

Are there any family or social issues you would like to discuss?	Yes	No
Any concerns about your child's behavior (i.e. tantrums, socializing)?	Yes	No
Does your child receive consistent discipline/teaching/setting limits?	Yes	No

Safety/Preventative Health:

Does your child use a car seat or booster 100% of the time?	Yes	No
Is your home/car a smoke-free environment?	Yes	No
Are you brushing your child's teeth with fluoride toothpaste?	Yes	No
Has your child seen a dentist?	Yes	No
Does your child participate in regular physical activity? (about 1 hr play/sport)	Yes	No
Does your child always wear a helmet when riding bike/scooter/skiing/etc?	Yes	No
Have you discussed "stranger danger" with your child?	Yes	No
Do you own a gun? Yes No If yes, is it stored safely (i.e. locked case)?	Yes	No

Are your child's immunizations up to date?	Yes	No
Does your child have any allergies (that you know of)?	Yes	No

Please list any medications or supplements your child took this week: _____

_____