Reedsburg AREA MEDICAL CENTER Physicians Group

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Patient Questionnaire – Four-Year Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic stress at home
Nutrition	
Types of intake (please circle)	Eggs Fruits Junk food Non-nutritional Cereals Fish Juices Meats Vegetables Cow's Milk
Junk Food (please circle)	Candy Desserts Fast Food Soda Sugary Drinks Chips
Dental	
Has dental home (please circle)	Yes No
Brushes teeth regularly (please circle)	Yes No
Flosses teeth regularly (please circle)	Yes No
Last dental exam (please circle)	Less than 6 months ago 6-12 months ago More than a year ago

Please see reverse side

Elimination	
Elimination Problems (please circle)	Diarrhea Urinary Symptoms Constipation Gas
Toilet Training (please circle)	Not started In process Complete
Behavior	
Behavioral Issues (please circle)	Biting Stubbornness Performing poorly at school Hitting Throwing tantrums Misbehaving with peers Misbehaving with siblings
Disciplinary Methods (please circle)	Consistency among caregivers Scolding Taking away privileges Ignoring tantrums Spanking Time outs Praising good behavior
Sleep	
Sleep Location (please circle)	Own Bed Parent's Bed **Average sleep duration in hours: _____**
Child Snores (please circle)	Yes No
Sleep Problems (please circle)	Yes No

Safety/Environment			
Smoking in home (please circle)	Yes	No	
Working smoke alarms (please circle)	Yes	No	Don't know
Guns in home (please circle)	Yes	No	
Working CO (carbon monoxide) alarms (please circle)	Yes	No	Don't know
Car seat (please circle)	Yes	No	

Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for dyslipidemia (please circle)	Yes No	**Risk factors for lead toxicity** (please circle)	Yes No
Risk factors for anemia (please circle)	Yes No		

Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider
Days per week at daycare: _____ **Hours per day at daycare: _____**	
Sibling interactions (please circle)	Good Fair Poor

Growth and Development

Do you or your family/childcare provider have concerns about your child's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your child:

Have behavioral or emotional development that causes you significant concern? (please circle)

Yes No

Do what most 4-year-olds can do? (please circle)

Yes No

Speak in sentences? (please circle)

Yes No

Have speech that is understandable to strangers? (please circle)

Yes No

Please see reverse side

Growth and Development Cont.

Does your child:

Copy a circle? (please circle)

Yes No

Dress self with help? (please circle)

Yes No

Understand basic concepts, such as "on," "under," "big," and "little"? (please circle)

Yes No

Play games with other children? (please circle)

Yes No