3 1/2 - 4 YEAR OLD HEALTH ASSESSMENT

Date: *……/……/……..*

Parent / Guardian - Please complete questionnaire about your child prior to seeing doctor

Child's Name:

……..

D.O.B……...

Address: ……..

……

……

Email: ……..

Next of Kin:-

Mother: ……..

Father: ……..

Siblings: ……Age: …….

……Age: …….

……Age: ……...

……..…Age: ..…..

Past Medical History

Birth ☐ Term

☐ Pre-term …….. Weeks

Low weight at birth ☐ Yes

☐ No

☐ Normal vaginal delivery

☐ Caesarean

Past Medical Conditions

……

……

Past Surgical Procedures

……

……

Congenital Conditions

……

……

Past Injuries (e.g. falls, head injuries)

……

……

Medication

Short term ……..

Long term ……

Allergies

……

……

Paediatrician ……

Consent for Health assessment: (Parent to sign) ……

Completed by: (Nurse to sign) …….

Assessment reviewed by: (Doctor to sign) ……

3 1/2 - 4 YEAR OLD HEALTH ASSESSMENT

Name: ……. D.O.B. …….

EYES

Family history of eye problems?

☐ Yes. Please list

……..

……..

……..

☐ No

☐ Not known

Parental concerns with child's vision?

☐ None identified

☐ Yes. Please list

……..

……..

HEARING

☐ Listening

☐ Follows instructions

History of

Ear infections ☐ Yes ☐ No

Chronic discharge ☐ Yes ☐ No

Recurrent/chronic otitis media?

☐ Yes ☐ No

Parental concerns with child's hearing?

☐ None identified

☐ Yes. Please list

……..

……..

ORAL HEALTH

Brushes teeth ☐ Once daily

☐ Twice daily

Type of toothbrush

Normal ☐

Battery ☐

Dental visits

☐ Yes ☐ No

Parental concerns with child's oral health?

☐ None identified

☐ Yes. Please list

……..

……..

EATING HABITS

Appetite

☐ Poor ☐ Good ☐ Excellent

Variety of food Comments

☐ Meats ……..

☐ Vegetables ……..

☐ Fruit ……..

☐ Dairy ……..

☐ Processed foods ……..

Variety of drinks

☐ Water ……..

☐ Milk ……..

☐ Fruit juice ……..

☐ Soft drinks ……..

3 1/2 - 4 YEAR OLD HEALTH ASSESSMENT

Name: ……. D.O.B. …….

SPEECH & LANGUAGE DEVELOPMENT

☐ Stutters

☐ Lisp

☐ Clear speech

☐ Uses sentences

☐ Participates in conversation

☐ Initiates conversation

Parental concerns with child's speech?

☐ None identified

☐ Yes. Please list

……..

……..

FINE & GROSS MOTOR SKILLS

Picking up small objects

☐ Yes ☐ No

☐ Walking ☐ Running

☐ Jumping ☐ Hopping

☐ Climbing stairs

☐ Riding bicycle / tricycle

☐ Right-handed ☐ Left-handed

Parental concerns with child's motor skills?

☐ None identified

☐ Yes. Please list

……..

……..

TOILET HABITS

Toilet-trained	☐ Yes	☐ No
Bowels	☐ Yes	☐ No
Bladder	☐ Yes	☐ No
Daytime	☐ Yes	☐ No
Night-time	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhoea	☐ Yes	☐ No

Parental concerns with child's toilet habits?

☐ None identified

☐ Yes. Please list

……..

……..

PHYSICAL ACTIVITY

Time spent active play (per day)

Indoors ……

Outdoors ……..

Time spent (per day)

TV …… -Reading ……

Computer games ……..

Quiet times ……..

Day time sleep ……..

Parental concerns with child's general health?

☐ None identified

☐ Yes. Please list

……..

……..

3 1/2 - 4 YEAR OLD HEALTH ASSESSMENT

Name: ……. D.O.B. …….

MOOD & BEHAVIOUR

Sleeping

- ☐ All night
- ☐ Wakes frequently
- ☐ Hard to get to bed
- ☐ Other ……

……

……

Energy levels

- ☐ Normal
- ☐ High
- ☐ Low

Ability to separate from main carer

- ☐ OK
- ☐ Most of time
- ☐ Distressed

Interaction with other children, adults, siblings

- ☐ OK
- ☐ Not much contact

With other children

- ☐ Day care / Kindy

…… Times per week

Parental concerns with child's mood & behaviour?

- ☐ None identified
- ☐ Yes. Please list

……..

……..

ALLERGIES

Medication ☐ Yes ☐ No

Grasses/Pollen ☐ Yes ☐ No

Foods

Milk ☐ Yes ☐ No

Wheat ☐ Yes ☐ No

Nuts ☐ Yes ☐ No

Other ……..

ANY OTHER CONCERNS

3 1/2 - 4 YEAR OLD HEALTH ASSESSMENT

Name: ……. D.O.B. …….

NURSE/DOCTOR to complete

EYES – Visual Inspection

☐ Clear ☐ Bright

☐ Signs of infection ☐ Redness

☐ Pupil size

☐ Fixation

☐ Tracking

Using eye chart (REVISED SHERIDAN GARDINER & REDUCED SNELLEN)

☐ Identifies well

NEAR ☐ Both N/ ☐ Right N/ ☐ Left N/

FAR ☐ Both 6/ ☐ Right 6/ ☐ Left 6/

☐ Colours

Referral indicated? ☐ Yes ☐ No

ORAL HEALTH – Visual Inspection of mouth

TEETH

Clean ☐ Yes ☐ No

White ☐ Yes ☐ No

Discolouration ☐ Yes ☐ No

Decay evident ☐ Yes ☐ No

GUMS

Clean ☐ Yes ☐ No

Ulcers ☐ Yes ☐ No

TONGUE

Clean ☐ Yes ☐ No

Referral indicated? ☐ Yes ☐ No

FINE & GROSS MOTOR SKILLS - Observed

Picking up small objects

☐ Yes ☐ No

Drawing without scribbling

☐ Yes ☐ No

Referral indicated? ☐ Yes ☐ No

NURSE/DOCTOR to complete

WEIGHT: ……

HEIGHT: ……

TEMPERATURE: …….

HEARING – Visual Inspection

Visual inspection of ears

☐ Clean

☐ Visible wax

☐ Odour

☐ Whisper test

Referral indicated? ☐ Yes ☐ No

SPEECH & LANGUAGE DEVELOPMENT - Observed

☐ Speech clear

☐ Understands directions

☐ Uses sentences

☐ Can make themselves understood

☐ Participates in conversation

☐ Initiates conversation

Referral indicated?

☐ Yes ☐ No

MOOD & BEHAVIOUR – Observed at assessment

☐ Interested ☐ Shy

☐ Interacts ☐ Clingy

☐ Cooperates during interview

Referral indicated? ☐ Yes ☐ No