PEDIATRIC FORM AGE 3-5 YEARS

Nutritional review	Language and Hearing
What kind of snacks does this child eat? Are meals at regular times? __yes __no Comments:	__Stuttering __ Not Hearing __ Not Talking Comments:

Development (check all that apply)

__Speak in sentences	__off bottle at age ___	__counts
__dresses self with/without help	__scribbles	__recognizes alphabet
__toilet trained	__draws circles/squares	__recognizes color
__attends day care or nursery school		__writes name

Does your child get along with family members? __yes __no _____

Has your child been sick more than 10 days in the past year? __yes __no

System review (check all that apply)

__frequent or severe headaches	__black or bloody bowel movements
__dizzy or fainting spells	__nose, mouth,throat problem or trouble speaking
__fevers	__chest pain or pressure
__black outs or convulsions	__shortness of breath or trouble breathing
__eye problems or trouble seeing	__swelling of ankles
__ear problems or trouble hearing	__rapid heartbeat or skipped beats
__coughing or wheezing	__difficulty or pain when urinating
__easy bruising	__urination color chang or frequency
__swelling or lumps anywhere on body	__pain or soreness on genitals or drainage from penis
__pain or swelling in joints, back or muscles	__itching or irritation of genital area or vaginal discharge
__not moving arms or legs	__increased tension or nervousness
__staggering or weakness	__trouble sleeping or nightmares
__tingling in feet or hands	__change i weight (over/under)
__loss of memory	__allergies
__loss of appetite	__rash or skin problems
__dental cavities	__failure to use car seat or automobile seat belt
__problems with swallowing or digestion	__toilet training __day __night __both
__pain in stomach or abdomen	__has not been screened for sickle cell if non-white
__change in bowel habits	
__blood in vomit	