



SWYC:TM 60 months

59 months, 0 days to 65 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

These questions are about your child's development. Please tell us how much your child is doing each of these things. If your child doesn't do something any more, choose the answer that describes how much he or she used to do it. Please be sure to answer ALL the questions.

	Not Yet	Somewhat	Very Much
Tells you a story from a book or tv	0	1	2
Draws simple shapes - like a circle or a square	0	1	2
Says words like "feet" for more than one foot and "men" for more than one man	0	1	2
Uses words like "yesterday" and "tomorrow" correctly	0	1	2
Stays dry all night	0	1	2
Follows simple rules when playing a board game or card game	0	1	2
Prints his or her name	0	1	2
Draws pictures you recognize	0	1	2
Stays in the lines when coloring	0	1	2
Names the days of the week in the correct order	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child... Seem nervous or afraid?	0	1	2
Seem sad or unhappy?	0	1	2
Get upset if things are not done in a certain way?	0	1	2
Have a hard time with change?	0	1	2
Have trouble playing with other children?	0	1	2
Break things on purpose?	0	1	2
Fight with other children?	0	1	2
Have trouble paying attention?	0	1	2
Have a hard time calming down?	0	1	2
Have trouble staying with one activity?	0	1	2
Is your child... Aggressive?	0	1	2
Fidgety or unable to sit still?	0	1	2
Angry?	0	1	2
Is it hard to... Take your child out in public?	0	1	2
Comfort your child?	0	1	2
Know what your child needs?	0	1	2
Keep your child on a schedule or routine?	0	1	2
Get your child to obey you?	0	1	2

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blackmon



pediatrics

Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? _____

Can you describe your child's nutritional habits?

- | | | | | |
|---------------------------|--------|----------|--------|---------|
| 1. Milk: | Whole | Low-fat | Soy | |
| 2. Appetite: | Good | Variable | Picky | |
| 3. Water Source: | City | Well | Spring | Bottled |
| 4. Variety of foods | Fruits | Veggies | Breads | Meats |
| 5. Multivitamin with iron | Yes | No | | |
| 6. Eats Breakfast | Yes | No | | |
| 7. Eats supper as family | Yes | No | | |

Is there any problems with hearing and vision?

- | | | | | | |
|--|-----|----|--|-----|----|
| 1. Do you have concerns about how your child sees? | Yes | No | 4. Do you have concerns about how your child hears? | Yes | No |
| 2. Has your child failed a school vision test? | Yes | No | 5. Do you have concerns about how your child speaks? | Yes | No |
| 3. Does your child tend to squint? | Yes | No | | | |

Has there been any foreign travel in the past 60 days or foreign adoption? Yes No

Has there been any exposure to smoking? Yes No Who: _____

Lead Screening (please answer for ages 2 year, 3 year, 4 year, 5 year, and 6 year)

- | | | |
|---|-----|----|
| 1. Does your child live in or regularly visit a house built before 1950? | Yes | No |
| 2. Does your child live in or regularly visit a house built before 1978 with recent renovations? | Yes | No |
| 3. Does your child have a sibling or playmates that have or have had lead poisoning? | Yes | No |
| 4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? | Yes | No |

Immunizations

- | | | |
|---|-----|----|
| 1. Previous reactions to immunizations | Yes | No |
| 2. Have family members been immunized (mom, dad, sibling) | Yes | No |
| 3. History of chicken pox in child being seen | Yes | No |
| 4. Serious illness at home or relatives (cancer) | Yes | No |
| 5. Allergic to eggs, gelatin, Neomycin, yeast | Yes | No |

Please describe your social history.

- | | |
|----------------------|----------------------|
| 1. Race: _____ | 4. Ethnicity: _____ |
| 2. Language: _____ | 5. # Siblings: _____ |
| 3. Lives With: _____ | |

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes No Specify: _____

Have there been any changes in your child's medical needs?

- | | | | |
|--|-----|----|----------------|
| 1. New Problems or illness | Yes | No | Specify: _____ |
| 2. Please list current medications (prescription and over-the-counter) _____ | | | |

