**La Loma**
**3-Year-Old Well Child**

**Name:_____ DOB:_____ Age:_____**

| | | |
|---|---|---|
| **Medications:** | | |
| Is your child on any medications? | YES | NO |
| If Yes, Please List: | | |
| **Allergies:** | | |
| Does your child have any allergies to medications? | YES | NO |
| **Sensory:** | | |
| **Vision:** | | |
| Does your child appear to be able to see well? | YES | NO |
| **Hearing/Speech:** | | |
| Does your child appear to be able to hear? | YES | NO |
| Is your child's speech understandable 75% of the time by most people? | YES | NO |
| **Development:** | | |
| Does your child have a large vocabulary? | YES | NO |
| Does your child speak in complete sentences? | YES | NO |
| Can your child jump in place? | YES | NO |
| Can your child balance on one foot? | YES | NO |
| Can your child ride a tricycle? | | |
| Does your child know his/her own name, age and sex? | YES | NO |
| Can your child scribble? | YES | NO |
| Can your child throw overhand? | YES | NO |
| Can your child put on clothing? | | |
| **Nutrition:** Does our child overall eat well (eat a generally diverse balanced diet)? | YES | NO |
| Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron | YES | NO |

**Do you have any concerns regarding your child? []NO [] YES (Explain Below)**

| |
|---|
| |
| |
| |

Signed_____ Printed Name_____

Relationship to Patient? _____ Date_____

Reviewed with Above_____

## La Loma Internal Medicine and Pediatrics

## Child COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child. Explain all yes answers at the end of the last page.

**GENERAL:** **Date:** _____

| | | |
|---|---|---|
| When was your child's last physical? | Date | |
| Has your child had a recent UNEXPLAINED loss of weight? | YES | NO |
| Does your child have a fever? | YES | NO |
| Does your child have excessive fatigue? | YES | NO |
| Does your child have an acceptable appetite? | YES | NO |

**EARS, EYES, NOSE, THROAT:**

| | | |
|---|---|---|
| Does your child have any drainage from eyes? | YES | NO |
| Does your child have any redness or irritation in eyes? | YES | NO |
| Does your child complain of itchy watery eyes? | YES | NO |
| Does your child have a sore throat? | YES | NO |
| Does your child have Nasal Congestion? | YES | NO |
| Does your child have frequent runny noses? | YES | NO |
| Does your child suffer from frequent bloody noses?<br>If so, how many per week? | YES | NO |
| Does your child complain of sinus pressure? | YES | NO |
| When was your child's last eye exam? | Date | |

**PULMONARY/ LUNGS:**

| | | |
|---|---|---|
| Is your child frequently short of breath? (If yes, AT REST or WITH ACTIVITY) | YES | NO |
| Does your child cough up sputum or mucus <u>most days?</u> | YES | NO |
| Does your child cough up blood? | YES | NO |
| Has your child had a continuous cough for longer than two to three months? | YES | NO |
| Does your child cough with exercise? | YES | NO |
| Does your child Wheeze? | YES | NO |

**CARDIOVASCULAR/HEART:**

| | | |
|---|---|---|
| Does your child get chest pain often? | YES | NO |
| Does your child complain of a racing heart? | YES | NO |
| Do your child's extremities swell? | YES | NO |
| Does your child have trouble breathing while lying flat? | YES | NO |
| Does your child turn blue around the mouth or have rapid breathing during exercises? | YES | NO |
| Does the patient's mother or father have elevated cholesterol or heart disease? | YES | NO |
| Has your child ever had their cholesterol checked? | YES | NO |

**PATIENT NAME:** _____

**DATE OF BIRTH:** _____

**GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:**

| | | |
|---|---|---|
| Does your child complain OFTEN of stomach pains? | YES | NO |
| Does your child complain of frequent nausea? | YES | NO |
| Does your child have frequent vomiting? | YES | NO |
| Does your child have frequent diarrhea? | YES | NO |
| Does your child have bright red blood in stools? | YES | NO |
| Does your child have black tarry stools? | YES | NO |
| Does your child have frequent constipation? | YES | NO |
| Does your child have difficulty swallowing? | YES | NO |

**GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:**

| | | |
|---|---|---|
| Does your child often complain of burning or discomfort with urination? | YES | NO |
| Does your child have any blood in urine? | YES | NO |
| Does your child urinate more frequently than normal? | YES | NO |
| Does your child get up to urinate more than once per night? | YES | NO |
| Does your child have problems with incontinence? (uncontrolled loss of urine)? | YES | NO |
| Does your child have sores / lesions on genitals? | YES | NO |

**HEMATOLOGIC (BLOOD)**

| | | |
|---|---|---|
| Does your child have problems with bleeding or a history of hemophilia? (Circle which one) | YES | NO |
| Does your child have a history of anemia? | YES | NO |
| Does your child have swollen glands that do not resolve? | YES | NO |

**ENDOCRINE (GLANDS)**

| | | |
|---|---|---|
| Does your child have problems with excessive thirst? | YES | NO |
| Does your child have dry brittle hair and nails? | YES | NO |

**MUSCULOSKELETAL / SKIN**

| | | |
|---|---|---|
| Does your child complain often of joint pain? | YES | NO |
| Does your child have joints that swell or get red? (Circle which one or both) | YES | NO |
| Does your child often have a rash? | YES | NO |

**NEUROPSYCHIATRIC (NERVES, BRAINS)**

| | | |
|---|---|---|
| Does your child often have trouble sleeping? | YES | NO |
| Does your child appear depressed or often sad? | YES | NO |
| Does your child complain of frequent numbness of legs and feet? | YES | NO |
| Does your child complain of frequent weakness in extremities? | YES | NO |

**PATIENT NAME: _____**

**DATE OF BIRTH: _____**