3 Year Old Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's...

1. Bowel movements ☐ Yes ☐ No
2. Congestion or wheezing? ☐ Yes ☐ No
3. Skin color or rashes (circle one)? ☐ Yes ☐ No
4. Overall development? ☐ Yes ☐ No
5. Communication skills? ☐ Yes ☐ No
6. Lack of interest in toilet training? ☐ Yes ☐ No
7. Weight loss or gain? ☐ Yes ☐ No
8. Recurrent ear infections? ☐ Yes ☐ No
9. Nose bleeds or bruising? ☐ Yes ☐ No
10. Weakness with walking up stairs, running, or climbing? ☐ Yes ☐ No
11. Behavior at school, home, or daycare? ☐ Yes ☐ No
12. Food allergies? ☐ Yes ☐ No
13. Seasonal allergies? ☐ Yes ☐ No

Does your child...

14. Speak in sentences? ☐ Yes ☐ No
15. Interact positively with teachers and friends and babysitters and siblings? ☐ Yes ☐ No
16. Know 3 or more colors? ☐ Yes ☐ No
17. Sing songs ☐ Yes ☐ No
18. Have a good imagination? ☐ Yes ☐ No
19. Ride a tricycle? ☐ Yes ☐ No
20. Skip or hop? ☐ Yes ☐ No
21. Participate in a sport or other organized activity? ☐ Yes ☐ No

Answer the following:

22. Do you have smoke alarms? _____ Carbon monoxide detectors? _____

23. Does your child ride in a forward-facing infant safety seat? ☐ Yes ☐ No
24. Do you know infant CPR? ☐ Yes ☐ No
25. September through March visits: Have all caregivers and family members living in the home been vaccinated for the flu this season? ☐ Yes ☐ No
26. Are you giving your child a multivitamin with iron? ☐ Yes ☐ No
27. Is your child eating all food groups: fruits, meats, and vegetables? ☐ Yes ☐ No
28. Is your child off the bottle and on to a sipper cup with a hard plastic nipple? ☐ Yes ☐ No
29. Are you brushing your child's teeth? ☐ Yes ☐ No
30. Has your child seen the Dentist? ☐ Yes ☐ No
31. Is your child fully potty trained during the day? ☐ Yes ☐ No
32. Does your child ride in the back seat? ☐ Yes ☐ No
33. How many ounces of milk does your child drink in one day? _____ What kind? _____

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Answer the following:

34. Is your child exposed to cigarette smoke? ☐ Yes ☐ No
35. Were there any problems with immunizations in the past? ☐ Yes ☐ No
36. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No
37. Does your child eat non-food substances such as paint chips? ☐ Yes ☐ No
38. Does your child still use a bottle? ☐ Yes ☐ No
39. Does your child still use a pacifier? ☐ Yes ☐ No
40. Is your water source from a well? ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ☐ Yes ☐ No
2. Do any family members have a positive TB test? ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ☐ Yes ☐ No

Lead Screening:

Does your child...

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ☐ Yes ☐ No
4. Is your child a refugee from another country? ☐ Yes ☐ No
5. Does your child have their health insurance provided by Medicaid or INtotal Health? ☐ Yes ☐ No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ☐ Yes ☐ No

_____

_____

_____

_____

_____