4-5 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. Bed wetting, soiling, or urinary control? ☐ 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 long, meaningful sentences? ☐ Yes ☐ No
15. Interact positively with teachers and friends and babysitters and siblings? ☐ Yes ☐ No
16. Know all of his/her colors? ☐ Yes ☐ No
17. Sing songs ☐ Yes ☐ No
18. Have a good imagination? ☐ Yes ☐ No
19. Ride a tricycle or bike with training wheels? ☐ Yes ☐ No
20. Skip or hop? ☐ Yes ☐ No
21. Use crayons and scissors well? ☐ Yes ☐ No
22. Dress him/her self? ☐ Yes ☐ No
23. Separate from you without too much difficulty? ☐ Yes ☐ No
24. Participate in a sport or other organized activity? ☐ Yes ☐ No

Answer the following:

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

26. Do you know CPR? ☐ Yes ☐ No
27. September through March visits: Have all caregivers and family members living in the home been vaccinated for the flu this season? ☐ Yes ☐ No
28. Are you giving your child a multivitamin with iron? ☐ Yes ☐ No
29. Is your child eating all food groups: fruits, meats, and vegetables? ☐ Yes ☐ No
30. Is your child off the bottle? ☐ Yes ☐ No
31. Are you brushing your child's teeth? ☐ Yes ☐ No
32. Has your child seen the dentist? ☐ Yes ☐ No
33. Does your child ride in a booster seat or car seat in the back seat? ☐ Yes ☐ No
34. How many ounces of milk does your child drink in one day? _____ What kind? _____
35. How many ounces of juice does your child drink in one day? _____
36. Have you switched to low fat or skim milk? ☐ Yes ☐ No

4-5 Year Old Questionnaire

Answer the following:

37. Is your child exposed to cigarette smoke? ☐ Yes ☐ No
38. Were there any problems with immunizations in the past? ☐ Yes ☐ No
39. 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
40. Does your child eat non-food substances such as paint chips? ☐ Yes ☐ No
41. Does your child still use a pacifier? ☐ Yes ☐ No
42. Is your water source from a well? ☐ Yes ☐ No
43. Is your child on the computer or playing video games or watching TV more than 2 hours per day? ☐ 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
6. Do you plan to travel to a high risk country (one NOT listed above) within the next year? ☐ 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

_____

_____

_____

_____

_____

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	0	1	2
❊	Feel sad, unhappy	0	1	2
◆	Daydream too much	0	1	2
❑	Refuse to share	0	1	2
❑	Do not understand other people's feelings	0	1	2
❊	Feel hopeless	0	1	2
◆	Have trouble concentrating	0	1	2
❑	Fight with other children	0	1	2
❊	Down on yourself	0	1	2
❑	Blame others for your troubles	0	1	2
❊	Seem to be having less fun	0	1	2
❑	Do not listen to rules	0	1	2
◆	Act as if driven by a motor	0	1	2
❑	Tease others	0	1	2
❊	Worry a lot	0	1	2
❑	Take things that do not belong to you	0	1	2
◆	Distract easily	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____