3 Year Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health		
1. Do you have any concerns about your child's health?	NO	YES
2. Any problems with previous immunizations?	NO	YES
Feeding/Nutrition		
3. Giving your child fruits or vegetables at every meal?	YES	NO
4. Giving your child mostly whole grains?	YES	NO
5. Is your child drinking milk?	YES	NO
a. What type of milk?		
b. How much milk per day?		
6. Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
7. Giving any vitamins or supplements?	YES	NO
8. Does your child drink juice or other sweetened drinks?	NO	YES
Lipids		
9. Parents or grandparents with stroke or heart attack before age 55?	NO	YES
10. Parent with high cholesterol or on cholesterol medication?	NO	YES
Oral Health		
11. Are cavities a problem for you or anyone in your family?	NO	YES
12. Using a soft toothbrush to clean child's teeth twice a day?	YES	NO
13. Do you have a dentist for your child?	YES	NO
14. Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Elimination		
15. Child has a daily, soft bowel movement (poop)?	YES	NO
16. Do you have concerns about toilet training?	NO	YES
School		
17. Is your child in preschool or childcare?	YES	NO
Activity/Exercise/Screen time		
18. Does your child have more than 2 hours of screen time per day (TV, computer, video games)?	NO	YES
19. Is there a TV in your child's bedroom?	NO	YES
20. Do you read to your child every day?	YES	NO
21. Do you encourage activities such as walking, bicycling, swimming, or dancing?	YES	NO
22. Do you do educational activities as a family, such as go to museums, zoos, or libraries?	YES	NO
23. Do you eat meals together as a family?	YES	NO
24. Do you spend time alone with each of your children?	YES	NO
25. Do you spend time alone with your partner?	YES	NO
Sleep		
26. Do you have concerns about your child's sleep?	NO	YES
27. Does your child snore more than a little?	NO	YES

Social Stressors		
28. Are you able to take a little time for yourself?	YES	NO
29. Does your partner every hurt you or your children?	NO	YES
30. Any major changes or stresses in your family recently?	NO	YES
31. Do you ever worry your family will go hungry?	NO	YES
32. Do you have daycare concerns?	NO	YES

Behavior		
33. Excessive tantrums?	NO	YES
34. Questions about discipline?	NO	YES
35. Do you praise your child when he is behaving well?	YES	NO
36. Do you give your child choices?	YES	NO

Development		
37. Puts 2 or 3 sentences together?	YES	NO
38. Usually understandable, even to non-family members?	YES	NO
39. Counts to five or more?	YES	NO
40. Know two or more colors?	YES	NO
41. Pretend play, such as using a telephone or playing house?	YES	NO
42. Draws a person with two body parts?	YES	NO
43. Walks up and down stairs alternating feet?	YES	NO
44. Feeds self completely using fork and spoon?	YES	NO
45. Dress or undress with minimal help?	YES	NO
46. Throws a ball overhand?	YES	NO
47. Balances on one foot?	YES	NO
48. Toilet-trained during the day?	YES	NO
49. Names a friend?	YES	NO

Lead		
50. Regularly spends time in a house built before 1978?	NO	YES
a. Any peeling or chipping paint?	NO	YES
b. Any recent, ongoing or planned remodeling?	NO	YES
51. Has a sibling or playmate who ever had lead poisoning?	NO	YES

Safety		
52. Do you watch your child when she plays outside?	YES	NO
53. Do you talk to your child about stranger safety?	YES	NO
54. Does your child know that private parts are private?	YES	NO
55. Do you keep your child away from vehicles, lawn mowers, driveways, and streets?	YES	NO
56. Wears a helmet when on a tricycle, bicycle or scooter?	YES	NO
57. Is your child exposed to anyone who smokes?	NO	YES
58. Is there a gun in the home?	NO	YES
a. Is it locked or in a safe?		
59. Child rides in a safety seat, in the back seat?	YES	NO
60. Do you apply sunscreen when outside for a long time?	YES	NO
61. Do you ever leave your child alone in the car, house, or yard?	NO	YES
62. Keep furniture away from windows or use window guards?	YES	NO

Tuberculosis		
63. Has a family member or contact had tuberculosis disease?	NO	YES
64. Has a family member had a positive TB skin test (PPD)?	NO	YES
65. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES

66. Has your child traveled to a high-risk country for more than a week?	NO	YES

Review of Systems

67. Any concerns about your child's hearing?	NO	YES
68. Any concerns about your child's vision?	NO	YES