

### 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

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