3 Years Questionnaire

History

Do you have any concerns about your child?

Yes No

Does your child have any special health care needs?

Yes No

Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

Has your child had any procedures or tests done since their last visit?

Yes No

Household

How many people, not including your child, are living in this child's home? _____

If this child is not living with both biological parents, what is living situation?_____

Social History

Have there been any major changes for your child or in your family lately?

Yes No

*Who takes care of your child during the day?*_____

*What are your plans for childcare over the next year?*_____

Does your child live with anyone who smokes or spend time in any places where people smoke?

Yes:_____ No

Does anyone smoke in the car your child travels in?

Yes No

Anemia Risk Assessment

Has your child ever been diagnosed with iron deficiency anemia?

Yes No

Do you ever have trouble getting food on the table?

Yes No

Is your child on a strict vegetarian diet?

Yes No

Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

Yes No

Lead Risk Assessment

Does your child have a sibling or playmate who has or had lead poisoning?

_____

*Does your child spend time in a house or child care facility that was built before 1978 that is under renovations or remodeling or had been within the last 6 months?*_____

Does your child spend time in a house or child care facility that was built before 1950?

_____

*Does your child eat or drink out of pottery or ceramic dishes? Do you cook with pottery or ceramic pots or pans?*_____

If your child was adopted, was the adoption from another country?

Yes No Not adopted

Has your child recently immigrated from another country?

Yes No

Does this child have any caregivers that do any smelting, soldering, or auto body repair?

Yes No

Do you give your child any home or folk remedies?

Yes:_____ No

Tuberculosis Risk Assessment

Has your child been exposed to someone with tuberculosis?

Yes No

Has a family member or contact had a positive tuberculin skin test?

Yes No

Was your child born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?

Yes No

Has your child traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?

Yes No

Is your child infected with HIV?

Yes No

Nutrition

How many servings of dairy products does your child have per day? For example, yogurt and cheese.

Less than 2 2-3 More than 3

How many servings of vegetables does your child have per day?

Less than 2 2-3 More than 3

How many servings of fruits does your child have per day?

Less than 2 2-3 More than 3

How many servings of whole grains does your child have per day?

Less than 4 4-6 More than 6

How many servings of protein does your child have per day? For example, meat, eggs, beans, tofu, etc.

Less than 2 2-4 More than 4

How many servings of junk food does your child have per day? For example, chips, candy, cookies, cakes, etc.

_____

How often does your child have a fast food meal?

1 per day 4-6 a week 1-3 a week 1-3 a month 6-11 a year 1-5 a year never

How many ounces (oz) of milk does your child drink per day?_____ oz

How many ounces (oz) of juice does your child drink per day?_____oz

How many ounces (oz) of soda or drink mixes like Kool-Aid does your child drink per day?_____ oz

Does your child take vitamins or supplements?

Yes No

Does your child watch TV while eating?

Yes No

Does your child have any problems with eating?

Yes No

Elimination

Does your child have any problems with urinating or going pee?

Yes No

Does your child have any problems with bowel movements or going poop?

Yes No

Is your child toilet trained?

During the day and most nights

During the day but not at night yet

Not yet

In progress

Sleep

How many hours does your child sleep per day?_____ hours

Does your child have problems with sleeping?

Yes No

Oral Health

How often are your child's teeth brushed?

Once a day

Twice a day

Does not brush teeth

How often does your child floss teeth?

Once a day Twice a day Does not floss teeth

How often does your child see the dentist?

Once a year Twice a year Does not see dentist regulary

Is your child drinking water that is fluoridated?
Yes No
Has your child had fluoride varnish applied to their teeth in the last 6 months?
Yes No Not previously recommended
Does your child continually drink from a bottle or sippy cup throughout the day?
Yes No
Does your child snack frequently?
Yes No
Have you, the parent or primary caregiver, had any cavities in the last 12 months?
Yes No
Is your child eligible for Medicaid?
Yes No

Physical Activity

How many hours a day does your child spend being physically active? _____
Is your family physically active together?
Yes No
How many hours a day does your child spend watching TV or other electronic device screen? For example, computer, tablet, game console?
Never Less than 2 hours More than 3 hours

Development

Do you read or play rhyming games with your child?
Yes No
When reading together, do you ask your child questions about the pictures or stories?
Yes No
Do you take your child to parks, museums, libraries or participate in other educational activities outside the home?
Yes No

Behavior

Does your child play with other children like in playgroups or childcare?
Yes No
Does your child have a best friend or group of friends?
Yes No

Is your child cooperative?
Yes No
Do you provide your child with choices?
Yes No
Are all caregivers giving the same amount of patience, setting the same limits and doing the same discipline?
Yes No
What type of discipline do you use? _____

Does your child have trouble with hitting or biting?
Yes No

Safety

When your child rides in a car, do you use a car seat?
Every time Occasionally Never
Where, in the car, is the car seat located?
Front seat Back Seat
Which way is the car seat facing?
Forward Rear
Are there working smoke detectors in the house?
Yes No
Are there working carbon monoxide detectors in the house?
Yes No
Do you have a fire escape plan?
Yes No
Do you have a list of emergency numbers that are easy to find?
Yes No
Do you feel safe in your home?
Yes No
Do you feel safe in your community?
Yes No
Do you know how or where to get help if you don't feel safe in your home?
Yes
No
In places where this child spends time, are medications, chemicals and insecticides kept locked up?
Yes No
Is the phone number for Poison Control easily located?
Yes No
Is your child left alone on high places like changing tables or countertops?
Yes No
Do you keep furniture away from windows?
Yes No

Is your child able to climb out of their crib?
Yes No
Are your stairs gated at the top and bottom?
Yes No
Do you watch your child when they play outside?
Yes No
When playing outside, does your child stay within fences and gates?
Yes No
Do you watch your child closely when playing near streets or driveways?

Yes No

Do you keep your child away from moving machines, lawn mowers, streets and driveways?

Yes No

Are the cords to window blinds out of your child's reach?

Yes No

Do you stay within arms reach of your child when near water like bath tub and swimming pools?

Yes No

Is there a swimming pool, pond, or lake near your home or where your child spends time?

Yes No

Is the temperature of your hot water at or below 120?F in the places your child frequents? (For example, at home, at babysitter's or daycare)

Yes No Unknown

Are there barriers around space heaters, woodstoves or kerosene heaters?

Yes No

Are cigarettes, lighters, matches and alcohol out of your child's sight and reach?

Yes No

Does your child wear sunscreen or sun protective clothing when outside?

Yes No

Does your child wear a helmet when riding a tricycle, bicycle, scooter, skateboard, skis or snowboard?

Yes No

Have you taught your child how to safely approach pets?

Yes No

Are there any guns in your home or where your child spends time?

Yes No Unknown

Are you comfortable answering your child's questions about their body?

Yes No

Does your child know it is never ok for an older child or adult to ask to see their private parts?

Yes No

Can your child:

name 1 color
Yes No
name 4 pictures
Yes No
sentences of 3 - 4 words
Yes No
copy a circle
Yes No
place small objects in a small opening
Yes No
thumb wiggle
Yes No
tower of 6 blocks
Yes No
tower of 9 blocks
Yes No
balance on each foot 1 second
Yes No
broad jump
Yes No
pedals tricycle
Yes No
*throw ball overhand **
Yes No
*brush teeth with help **
Yes No
feeds self w/o difficulty
Yes No
name friend
Yes No