

Name: _____ Date of birth: _____

Health Status Questionnaire – 3 Years

Child lives with: mother father both parents other: _____

Childcare: daycare/preschool babysitter stays at home other: _____

Eating habits:

__ meals __ snacks __ grazes __ picky __adequate fruits/veggies

__ mostly meats/starches __ lots of juice(should be <6oz per day)

Milk/dairy products: __ times per day

Toilet habits: normal day trained not trained

Stool pattern: regular irregular hard runny soft

Sleep: sleeps 9-10 hrs at night sleeps < 9hrs at night naps

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Pretend play? Y N

Speak in 3-4 word sentences and usually understandable? Y N

Name a friend? Y N

Name objects? Y N

Know his/her sex (boy,girl)? Y N

Stack 6-8 blocks/objects? Y N

Stand on 1 foot for few seconds? Y N

Throw overhand? Y N

Walk upstairs alternating feet? Y N

Copy circle on paper? Y N

Draw a person (2 parts)? Y N

Vision screen:

Does your child hold objects close when trying to focus or squint? Y N

Do your child's eyes appear unusual, seem to cross or be lazy? Y N

Do your child's eyelids droop or does one eyelid tend to close? Y N

Car seat use: Y N Smoke detectors: Y N

Sunscreen: Y N Fire extinguishers: Y N

Insect protection: Y N Firearms/guns in house: Y N

Home child proofed: Y N Locked away: Y N

Dental visit: Y N Passive smoke exposure: Y N

Do you limit your child to <1 hour a day of TV/computer/video game? Y N

Tuberculosis (Tb) Screen Questions:

Has your child ever received BCG (Tb vaccine given in some foreign countries)? Y N

Has there ever been tuberculosis/Tb in any household member? Y N

Was your child born or traveled for longer than 2 weeks to a country at high risk for
Tb (countries other than Canada, Australia, New Zealand or Western Europe)? Y N

Do you have any concerns about your child? _____