

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Health Status Questionnaire – 4 Years**

Child lives with: mother father both parents other: \_\_\_\_\_

Childcare: daycare/preschool babysitter stays at home other: \_\_\_\_\_

Eating habits:

\_\_\_ regular meals \_\_\_ snacks \_\_\_ grazes \_\_\_ skips meals \_\_\_ picky

\_\_\_ adequate fruits/veggies \_\_\_ mostly meat/carbs \_\_\_ fast food > 2x week

Milk/dairy products: \_\_\_ times per day \_\_\_ vegetarian

Activity: regular exercise active sports sedentary cannot tolerate exercise

Voiding habits: normal accidents during day bedwetting

Stool pattern: regular irregular hard runny soft accidents

Sleep: sleeps 9-10 hrs sleeps < 9hrs difficulty going to sleep wakes at night

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Interact well with peers? Y N

Fantasy play? Y N

Speak in 4-5 word sentences? Y N

Speak clearly? Y N

Know his/her age, name, and gender (boy,girl)? Y N

Name 4 colors? Y N

Draw a person (3 parts)? Y N

Hop on 1 foot? Y N

Balance on 1 foot for few seconds? Y N

Stack 8 tower of blocks/objects? Y N

Copy cross (+) on paper? Y N

Brush his/her own teeth? Y N

Dress his/her self? Y N

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

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? \_\_\_\_\_