



ABC Pediatrics

3 Year Pre-visit Questionnaire

Patient Name _____

Date _____

Bathes: (Daily) (Every other day)

Diet

Balanced Diet? _____ Picky eater? _____ Cups of milk daily _____

Problems with constipation? _____ Bed wetting? _____ # of hours sleeping at ONE time _____

Is there any secondhand smoke exposure in your home or car? _____

Developmental Milestones (check all that apply):

- Responds to questions
- Balances on 1 foot
- Copies shapes
- Dressed with supervision
- Imitates a bridge
- Interacts with peers
- Has pretend play
- Speech understood by caregiver
- Throws ball overhand
- Uses sentences

Any other questions or concerns you would like to discuss?

TB Screen	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO
Lead Risk	Does your child have a sibling or playmate that has had lead poisoning?	YES	NO
	Does your child live in or regularly visit a home built before 1978 that being renovated?	YES	NO
	Does your child live in or regularly visit a house or childcare facility built before 1950?	YES	NO

Weight _____ Height _____ BP _____ P _____ T _____ Vision _____