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? _____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time_____

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

Current Dentist:_____ Current Daycare:_____

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(GoCheck)_____