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):

- ☐ Uses 3-word sentences.
- ☐ Uses words that are 75% intelligible to strangers.
- ☐ Tells a story from a book or TV.
- ☐ Compares things using words such as bigger or shorter.
- ☐ Goes to the bathroom
- ☐ Eats independently.
- ☐ Draws a single circle.
- ☐ Draws a person with head and one other body part.
- ☐ Begins to play make-believe.
- ☐ Uses sentences

Any other questions or concerns you would like to discuss?

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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)__________