ABC Pediatrics

# 4 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/ Pre-K:__________________________

## Developmental Milestones (check all that apply):

| | | | |
|---|---|---|---|
| • Uses 4-word sentences | • Goes to the bathroom and has bowel movement by self | • Draws a simple cross | • Climbs stairs, alternating feet w/o support |
| • Uses words that are 50% intelligible to strangers | • Dresses and undresses w/o much help | • Unbuttons and buttons | • Skips on one foot |
| • Answers questions | • Plays make-believe | • Grasps a pencil w/thumb and fingers instead of a fist | |
| • Tells a story from a book | • Draws a person w/at least 3 body parts | • Draws recognizable pictures | |

Any other 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_______ Hearing_______