Name: _____ Date of birth: _____

Health Status Questionnaire – 3 Years

Child lives with: mother father both parents other:_____

Childcare: daycare/preschool babysitter stays at home other:_____

Eating habits:

__ meals __ snacks __ grazes __ picky __adequate fruits/veggies

__ mostly meats/starches __ lots of juice(should be <6oz per day)

Milk/dairy products: ___ times per day

Toilet habits: normal day trained not trained

Stool pattern: regular irregular hard runny soft

Sleep: sleeps 9-10 hrs at night sleeps < 9hrs at night naps

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Pretend play?	Y	N
Speak in 3-4 word sentences and usually understandable?	Y	N
Name a friend?	Y	N
Name objects?	Y	N
Know his/her sex (boy,girl)?	Y	N
Stack 6-8 blocks/objects?	Y	N
Stand on 1 foot for few seconds?	Y	N
Throw overhand?	Y	N
Walk upstairs alternating feet?	Y	N
Copy circle on paper?	Y	N
Draw a person (2 parts)?	Y	N

Vision screen:

Does your child hold objects close when trying to focus or squint?	Y	N
Do your child's eyes appear unusual, seem to cross or be lazy?	Y	N
Do your child's eyelids droop or does one eyelid tend to close?	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

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

Updated 8/28/17