Name: ______________________________________ Date of birth: _______________

Health Status Questionnaire – 4 Years

Child lives with: mother father both parents other:__________________

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

Eating habits:

___ regular meals ___ snacks ___ grazes ___ skips meals ___ picky

___adequate fruits/veggies ___ mostly meat/carbs ___ fast food > 2x week

Milk/dairy products: ___ times per day ___ vegetarian

Activity: regular exercise active sports sedentary cannot tolerate exercise

Voiding habits: normal accidents during day bedwetting

Stool pattern: regular irregular hard runny soft accidents

Sleep: sleeps 9-10 hrs sleeps < 9hrs difficulty going to sleep wakes at night

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Interact well with peers?	Y	N
Fantasy play?	Y	N
Speak in 4-5 word sentences?	Y	N
Speak clearly?	Y	N
Know his/her age, name, and gender (boy,girl)?	Y	N
Name 4 colors?	Y	N
Draw a person (3 parts)?	Y	N
Hop on 1 foot?	Y	N
Balance on 1 foot for few seconds?	Y	N
Stack 8 tower of blocks/objects?	Y	N
Copy cross (+) on paper?	Y	N
Brush his/her own teeth?	Y	N
Dress his/her self?	Y	N
Do you limit your child to <1 hour a day of TV/computer/video game?	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

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