



30 Month Health Maintenance Questionnaire

Patient Name _____

Who accompanied child today?
(name and relationship to child) _____

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Feedings:

Does your child:

Feed him/herself well? Yes No

Use a spoon or fork? Yes No

Drink from a cup with one hand? Yes No

Have any foods he/she cannot tolerate? Yes No

If yes, list: _____

Eat a variety of food? Yes No

If no, what does child eat? _____

Any concerns with stooling or urination? _____

Is your child showing interest in toilet
training? Yes No

Sleep pattern:

Average hours of nighttime sleep: _____

Number of Naps? _____

Over Please

If you do not understand any of these questions, please ask your nurse.

Are there any smokers in the household?

Please list current medications:

Any allergies to medicine?

Does your child:

Jump up and down in one place?

Yes No

Throw a ball overhand?

Yes No

Wash and dry hands?

Yes No

Brush teeth with help?

Yes No

Put on clothes with help?

Yes No

Copy a vertical line?

Yes No

Use short phrases of three to four words?

Yes No

Is your child understandable to others

50% of the time?

Yes No

Know correct action of certain animals?

ie; cat meows, cow moos, bird flies

Yes No

Point to 6 body parts?

Yes No

If you do not understand any of these questions, please ask your nurse.