



3 year 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 entirely? Yes No

How many snacks between meals? _____

What does your child eat for snacks? _____

Does your child or any household member
drink water from a private well? Yes No
(consider vacation homes, relative's or
friend's home, daycare or school)

Elimination:

Any concerns about stooling or urination? _____

How is toilet training going? _____

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.

Medications:

Please list current medications:

Any allergies to medicine?

Does your child:

Alternate feet walking up stairs?	Yes	No
Jump forward?	Yes	No
Stand briefly on one foot?	Yes	No
Pedal a tricycle?	Yes	No
Build a stack of 7-9 blocks?	Yes	No
Draw a circle and imitate a vertical line?	Yes	No
Speak so others understand what he is saying?	Yes	No
Speak in sentences of 4-5 words?	Yes	No
Understand cold, tired, and hungry?	Yes	No
Understand bigger, smaller and on and under?	Yes	No
Name one color?	Yes	No
Brush teeth with help?	Yes	No
Put on some clothing and shoes without help?	Yes	No

Tuberculosis Screening Questionnaire:

Does your child have contact with adults with TB infection?

Yes No

Is child or parent from a region of the world with a high prevalence of TB?

Yes No

Is child frequently exposed to immunosuppressed persons, homeless people, nursing home residents, or migrant workers?

Yes No

Does either parent or other individual living in home work in a medically related field or have contact with institutionalized individuals or nursing home residents?

Yes No

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