



Health Maintenance Questionnaire

3 YEARS OLD

PATIENT NAME _____ BIRTH DATE ____/____/____ AGE TODAY _____

PARENTS _____ TODAY'S DATE ____/____/____

REASON FOR THIS CHECK UP: Headstart Pre-school Routine check-up Other:

PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below by checking YES or NO.

Explain "YES" answers in the space below.

HISTORY	Yes	No	PHYSICIAN'S COMMENTS
Does your child have a recurrent medical or psychological problem?			
List medications taken routinely: <input type="checkbox"/> none			
Has s/he ever had: a serious illness or stayed overnight in a hospital?			
an operation?			
Does s/he need to stop play and rest more than other kids his/her age?			
Has s/he seen a doctor outside of this clinic for any reason?			
Does your child need any immunizations as far as you know?			
Does your child have allergies: (circle) hay fever, asthma, hives, foods, medicine			
Are there any smokers in your child's home or daycare? <input type="checkbox"/> outside <input type="checkbox"/> other room			<input type="checkbox"/> Discussed risks of 2 nd hand smoke.
Are there any illnesses that run in your family?			
Has a close relative died before age 55 due to heart or cholesterol problems?			
How many servings a day does your child eat: Juice____ Pop____ Fruit____ Veg____ Meat____ Milk____ Milk products____			
Does your child usually drink water that is NOT fluoridated? <input type="checkbox"/> Don't know			<input type="checkbox"/> Prescribed fluoride vitamins.
Has it been more than 1 year since your child's last dental check-up?			<input type="checkbox"/> Recommended dental check up.
Do you have concerns about his/her vision or hearing?			

PLEASE TURN THE PAGE OVER AND ANSWER MORE QUESTIONS!!

Explain questions _____

answered with "yes." _____

Give approximate dates. _____

ASSESSMENT

1. See Physical Exam Summary and other side of this form for more information.
2. _____
3. _____
4. _____
5. _____
6. _____

PLAN

1. Anticipatory handouts given.
2. _____
3. _____
4. _____
5. _____
6. _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Child Guidance: age 3

Who does your child live with? _____

What activities is s/he involved in? _____

What does s/he like to do for fun? _____

Note if there are any specific behavior problems: _____

BEHAVIOR and DEVELOPMENT	Yes	No	PHYSICIAN'S COMMENTS
Is your child completely toilet trained?			
Does s/he sleep well?			
Can your child put his/her clothes on?			
Can s/he speak in 3 to 4 word sentences with clear speech?			
Can s/he copy a straight line after watching you draw it?			
Can your child pedal a tricycle?			
Does s/he usually watch less than 2 hours of TV, videos and computer games each day?			
Do you compliment his/her good behavior more than you correct bad behavior?			
SAFETY	Yes	No	
Have you discussed "stranger safety" and "inappropriate touching" with your child?			
Is the water temperature in your house less than 120 degrees?			
Do you have smoke detectors and a fire escape plan?			
Are guns in your home locked up with bullets stored separately? <input type="checkbox"/> No guns in our home			
Do you have the Poison Control Center's number handy?			
Does your child always ride in the back seat of your vehicle?			
Which of the following restraint systems does your child use in your vehicle? <input type="checkbox"/> Convertible car seat <input type="checkbox"/> Booster seat with built-in straps <input type="checkbox"/> Safety lap/shoulder belt alone <input type="checkbox"/> Built-in safety seat <input type="checkbox"/> Booster seat with lap/shoulder belt <input type="checkbox"/> Other			
NOTE: Nebraska law requires a safety seat until age 6, regardless of weight. Optimal safety requires a convertible car seat or a booster seat with built-in straps up to 40 pounds and a booster seat used with the vehicle's lap and shoulder belt between 40 and 80 pounds. Read your safety seat instructions for weight limits and your vehicle's owner's manual regarding the need for a locking clip, etc.			
TUBERCULOSIS (TB) RISK	Yes	No	TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low
Has your child been around anyone with contagious TB or a positive PPD test?			
Has your child had contact with people from Asia, Middle East, Africa or Latin America?			
Is anyone living in your house infected with HIV?			
Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers.			
Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?			
LEAD RISK	Yes	No	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low
Does your child live in or visit a house built before 1978?			
Is there a sibling or playmate with lead poisoning?			
Does your child live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways.			
Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead.			
Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?			

Who answered the above questions? _____ Thank you for helping us help you and your child!!

Please put this paper in the box hanging outside the door so that we know you are finished!