Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

3 – 4 Year Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about any of the following for your child? ..... Y N
   Height Weight Vision Hearing Sleeping Eating
2. Does your child get at least 5 servings of fruits/vegetables most days?. ..... Y N
3. Does your child get less than 2 hours of TV, movies or computer time per day? ..... Y N
4. Does your child get at least 1 hour of active play each day? ..... Y N
5. Does your child drink sweetened drinks like pop or juice? ..... Y N
6. Does your child regularly eat breakfast? ..... Y N
7. How many times in a week does your child eat fast food? _____
8. Are your child's teeth brushed every day? ..... Y N
9. Has your child been to a dentist this past year? ..... Y N
10. Is your child potty trained both day and night? ..... Y N
11. Do you and your partner agree on rules/discipline? ..... Y N
12. Has your child had any injuries since last visit? ..... Y N

SAFETY

13. Does your child always use a car seat in the back seat? ..... Y N
14. Do you know CPR and the rescue maneuver for choking? ..... Y N
    (www.americanheart.org – search Family and Friends CPR Anytime)
15. Are cleaning supplies and medicines stored up high or locked? ..... Y N
16. Do you have the poison control number 1-800-222-1222 handy? ..... Y N
17. Does your child spend time with anyone that smokes? ..... Y N
18. Is there a gun in your home? ..... Y N
    If yes, is it locked? ..... Y N
19. Do you put sunscreen on your child? ..... Y N
20. Do you have smoke/carbon monoxide alarms in your home? ..... Y N
21. Do you have any concerns regarding conflict or violence that your child might be exposed to? ..... Y N
22. Do you have any concerns regarding the use of alcohol or drugs by anyone caring for your child? ..... Y N

SOCIAL

23. Do you have any support or help in caring for your child? ..... Y N
24. Are there any new stresses or recent changes impacting your family (job change, move, divorce, illness)? ..... Y N

FAMILY MEDICAL HISTORY

25. In the past year has anyone in your child's extended family been diagnosed with a chronic illness? (such as heart disease, diabetes, kidney failure) ..... N Y

Please list below any questions or concerns that you would like to talk about today.

Parent / Guardian Signature and Date	Provider Signature and Date