4 Year Pre-Visit Questionnaire

Eastern Shore Children's Clinic

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME:_____ DATE OF BIRTH: _____

YOUR NAME:_____ RELATIONSHIP: _____

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:_____
_____
_____

Does your child have any allergies? YES/NO If yes, please list:_____
Does your child take any medications? YES/NO If yes, please list:_____
Has your child seen any other health care providers? YES/NO If yes, please list: _____

Have there been any recent changes in your family? (check all that apply)

____ Death ____ Divorce Other: _____
____ Job Change ____ Move _____

FEEDING/NUTRITION

Is your child drinking 2% milk? YES/NO If yes, how much in a day? _____ounces
What else does your child eat?_____
_____

BEHAVIOR/SOCIAL

	Never	Sometimes	All the time
Does your child seem nervous or afraid?			
Does your child seem sad or unhappy?			
Does your child get upset if things are not done a certain way?			
Does your child live with anyone who smokes or spend time in a place where people smoke?			
Has a family member's drinking or drug use ever had a bad effect on your child?			
In the past year did you ever worry that your food would run out before you got money to buy more?			

	Yes	No
Do you have concerns about how your child hears?		
Do you have concerns about how your child is talking?		
Do you have concerns about how your child sees?		
Do you have concerns about your child's development or behavior?		

	Yes	No
Does your child live in or visit a house build before 1950?		
Does your child live in or visit a house built before 1978 that has been renovated in the past 6 months?		
Does your child have a sibling or playmate who has had lead poisoning?		
Does your child have a family member who participates in a lead related job or hobby (casting or soldering – bullets, fishing weights, stained glass)?		
Does your child have a family member who uses traditional folk medicines or cosmetics or routinely imports food from abroad?		
Does your child live near lead smelters, battery recycling plants or other industries that might release atmospheric lead?		

	Yes	No
Has a family member or contact had tb or had a + skin test?		
Was your child born in a country at high risk for tb (any country other than the US, Canada, Australia, New Zealand or Western Europe)?		
Has your child traveled to a country other than the US, Canada, Australia, New Zealand or Western Europe and stayed longer than a week?		

	Yes	No
Are cavities a problem for you or for anyone in your family?		
Does your child see a dentist at least twice a year?		

DEVELOPMENTAL MILSTONES: Please put a check beside the things your child is able to do.

____ Hops on 1 foot
____ Toilet trained during the day
____ Draws a person with 3 body parts
____ Plays board or card games
____ Names 4 colors
____ Tells you a story from a book or tv
____ Copies a cross
____ Dresses himself
____ Knows name and age
____ Brushes own teeth
____ Other people can understand child