Fox Valley
WOMEN & CHILDREN'S
HEALTH PARTNERS
committed to providing full circle quality care

Got Questions? Get Answers. www.fvwchp.com

PATIENT NAME: ______________________________

Questions for 3 year visit

DATE: ______ / ______ / ______

Please complete the following questions as they apply to your child.

NUTRITION

What is your child drinking from?
❑ a cup (sippy or open) only
❑ a cup (sippy or open) mostly and a bottle occasionally
❑ a bottle mostly and a cup (sippy or open) occasionally)
❑ a bottle only

Is your child drinking milk? ❑ **yes** ❑ **no**
If yes, what type?
❑ whole ❑ 1% ❑ 2% ❑ skim ❑ soy ❑ rice ❑ formula

If yes, how much milk does your child drink per day?
❑ < 8 oz ❑ 8 to 16 oz ❑ 16 to 24 oz ❑ 24 to 32 oz ❑ > 32 oz

How much juice, Gatorade, sports drinks, and soda pop does your child drink per day?
❑ 0 to 4 oz ❑ 4 to 8 oz ❑ 8 to 16 oz ❑ > 16 oz

How much water does your child drink per day?
❑ < 8 oz ❑ 8 to 16 oz ❑ 16 to 24 oz ❑ > 24 oz

Your child has what type of water source?
❑ city ❑ well ❑ bottled with fluoride ❑ bottled without fluoride

What is your child eating?
❑ all table foods ❑ mostly table foods and some baby foods
❑ mostly baby foods and some table foods ❑ baby foods without any table foods

How many scheduled meals is your child offered per day?
❑ 1 to 2 ❑ 2 to 3 ❑ 3 to 4 ❑ > 4

How many snacks is your child offered per day?
❑ none ❑ 1 ❑ 1 to 2 ❑ >2

Has your child eliminated any main food groups from his/her diet?
❑ meats ❑ vegetables ❑ fruits ❑ grains/breads

ELIMINATION

How frequently does your child have a bowel movement?
❑ > every 4 days ❑ every 3 to 4 days ❑ every other day ❑ every day
❑ 1 to 2 times per day ❑ > 2 times per day

Is your child having a bowel movement on the toilet? ❑ **yes** ❑ **no**

If no, please select the statement that best describes your child:
❑ is starting to show interest ❑ was interested and now has no interest ❑ has no interest

Is your child having any problems with his/her bowel movements? ❑ **yes** ❑ **no**
If yes, please explain. ______________________________
____

Is your child urinating on the toilet? ❑ **yes** ❑ **no**

If no, please choose the statement that best describes your child:
❑ is starting to show interest ❑ was interested and now has no interest ❑ has no interest

Is your child having any problems with his/her urination? ❑ **yes** ❑ **no**
If yes, please explain. ______________________________
____

SLEEP

Does your child have a transitional object for sleep? ❑ yes ❑ no

Does your child have a fairly consistent bedtime? ❑ yes ❑ no

Is your child using a pacifier to fall asleep? ❑ yes ❑ no

Where does your child fall asleep?
❑ in his/her own room ❑ in a room with a sibling ❑ in his/her parents room ❑ elsewhere

How many hours does your child sleep at night?
❑ < 8 ❑ 8 to 10 ❑ 10 to 12 ❑ > 12

How many naps does your child take during the day?
❑ none ❑ 1 ❑ 1 to 2 ❑ > 2

Does your child have any problems with his/her sleep?
❑ snoring ❑ restless sleep ❑ paused or startled breathing ❑ difficulty falling asleep ❑ night terrors
❑ poor sleep quality (being tired after sleeping) ❑ frequent nighttime awakenings ❑ nightmares ❑ teeth grinding
❑ other: ______________________

VISION

Do you have any concerns regarding your child's vision? ❑ yes ❑ no

If yes, what? ______________________

HEARING

Do you have any concerns regarding your child's hearing? ❑ yes ❑ no

If yes, what? ______________________

SOCIAL AND PRESCHOOL/SCHOOL DEVELOPMENT

Does your child play well with other children?	❑ yes	❑ no	❑ evolving
Does your child get along with others at preschool/school?	❑ yes	❑ no	❑ evolving
Is your child adjusting well to preschool/school?	❑ yes	❑ no	❑ evolving

PERSONAL HABITS

How much TV does your child watch per day?
❑ none ❑ < 30 minutes per day ❑ < 1 hour per day ❑ 1 to 2 hours per day ❑ > 2 hours per day

DEVELOPMENT

Names at least one picture when you look at animal books together	❑ yes	❑ no
Enjoys sitting together for at least 5 minutes for story time	❑ yes	❑ no
Can answer "what" questions about a story that you just read together	❑ yes	❑ no
Throws a ball overhand (not side arm or underhand) toward your stomach or chest from a distance of about 5 feet	❑ yes	❑ no
Catches a large bounced ball with both arms extended	❑ yes	❑ no
Can kick a big ball	❑ yes	❑ no
Walks up and down stairs unassisted (using alternating feet)	❑ yes	❑ no
Helps put things away	❑ yes	❑ no
Appropriately answers the question, "Are you a boy or a girl?"	❑ yes	❑ no
Can name at least one color	❑ yes	❑ no
Speech is easily understood by most adults	❑ yes	❑ no
Talks in three word sentences most of the time	❑ yes	❑ no

SAFETY

What type of car seat does your child use?
❑ a 5 point (forward facing) toddler (convertible) seat in the back seat of the vehicle
❑ a (forward facing) booster seat in the back seat of the vehicle ❑ other: ______________________

Do you have a pool? ❑ yes ❑ no
If yes, what type?
❑ above ground without a fence ❑ in ground without a fence ❑ above ground with a fence around the pool
❑ above ground with a fence around the yard ❑ in ground with a fence around the pool ❑ in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider ______________________ Date: ______ / ______ / ______

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PATIENT NAME: ____

PROVIDER: __________________________ DATE: _____/_____/_____ ZIP CODE: ________________

Lead Screening

A documented result of a blood lead test or a properly filled out Childhood Lead Risk Assessment Questionnaire must be attached to a Certificate of Child Health Examination form for purposes of admission to an Illinois Department of Children and Family Services or state regulated child-care facility, including those operated by a school district.

Respond to the following questions by checking the appropriate answer.

Question			
Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	❑ Yes	❑ No	❑ Unknown
Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	❑ Yes	❑ No	❑ Unknown
Does this child live in or regularly visit a home that was built before 1978?	❑ Yes	❑ No	❑ Unknown
In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	❑ Yes	❑ No	❑ Unknown
Is this child a refugee or an adoptee from any foreign country?	❑ Yes	❑ No	❑ Unknown
Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	❑ Yes	❑ No	❑ Unknown
Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	❑ Yes	❑ No	❑ Unknown
At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	❑ Yes	❑ No	❑ Unknown

M.A.R. 5.2010 Signature of Provider ______________________________ Date: _____ / _____ / _____

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PATIENT NAME: ____________________ AGE: __________

PROVIDER: ____________________ DATE: _____/_____/_____

Tuberculosis Screening

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

Respond to the following questions by checking the appropriate answer.

Question			
Has a member of your family or a person who has contact with your child ad tuberculosis disease?	❑ Yes	❑ No	❑ Unknown
Has a family member had a positive tuberculin skin (TB) test?	❑ Yes	❑ No	❑ Unknown
Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries) like Mexico, South and Central America, Asia, India, and Eastern European countries?	❑ Yes	❑ No	❑ Unknown
Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week?	❑ Yes	❑ No	❑ Unknown

M.A.R. 5.2010 Signature of Provider ____________________ Date: ______ / ______ / ______