Reedsburg AREA MEDICAL CENTER
Physicians Group

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Patient Questionnaire – Three-Year Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic stress at home
Nutrition	
Types of intake (please circle)	Eggs Fruits Junk food Non-nutritional Cereals Fish Juices Meats Vegetables Cow's Milk
Junk Food (please circle)	Candy Desserts Fast Food Soda Sugary Drinks Chips
Dental	
Has dental home (please circle)	Yes No
Elimination	
Elimination Problems (please circle)	Diarrhea Urinary Symptoms Constipation Gas

Please see reverse side

Elimination Cont.	
Toilet Training (please circle)	Not started In process Complete
Behavior	
Behavioral Issues (please circle)	Biting Stubbornness Waking up at night Hitting Throwing tantrums
Disciplinary Methods (please circle)	Consistency among caregivers Scolding Ignoring tantrums Spanking Time outs Praising good behavior
Sleep	
Sleep Location (please circle)	Own Bed Parent's Bed **Average sleep duration in hours: _____**
Child Snores (please circle)	Yes No
Sleep Problems (please circle)	Yes No

Safety/Environment			
Home is child-proofed (please circle)	Yes	No	Partially
Smoking in home (please circle)	Yes	No	
Working smoke alarms (please circle)	Yes	No	Don't know
Guns in home (please circle)	Yes	No	
Working CO (carbon monoxide) alarms (please circle)	Yes	No	Don't know
Car seat (please circle)	Yes	No	

Screening				
Immunizations up-to-date (please circle)	Yes	No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes	No	**Risk factors for lead toxicity** (please circle)	Yes No
Risk factors for anemia (please circle)	Yes	No		

Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider

Days per week at daycare: _____

Hours per day at daycare: _____

Sibling interactions (please circle)	Good Fair Poor

Growth and Development

Do you or your family/childcare provider have concerns about your child's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your child:

Have behavior or emotional development that makes you concerned? (please circle)

Yes No

Concern you because of lack of speech or social skills? (please circle)

Yes No

Show interest and play with other children? (please circle)

Yes No

Pretend play (example: talk on the phone)? (please circle)

Yes No

Help with dressing, wash hands? (please circle)

Yes No

Imitate vertical line or copy a circle you draw? (please circle)

Yes No

Use 2 to 4 word sentences? (please circle)

Yes No

Please see reverse side

Growth and Development Cont.

Does your child:

Have speech that is understandable most of the time? (please circle)

Yes No

Name animal pictures? (please circle)

Yes No

Throw ball overhand? (please circle)

Yes No

Jump up and down? (please circle)

Yes No

Pedal tricycle, if available? (please circle)

Yes No N/A

Lead Screening

Does your child have siblings or playmates with lead poisoning? (please circle)

Yes No

Enrolled in Medicaid or WIC? (please circle)

Yes No

Lives in or visits a home or building built before 1950? (please circle)

Yes No

Lives in a home or building built before 1978 with recent or ongoing renovations? (please circle)

Yes No