6 Month to 3 Year Visit Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Birthdate:**_____ **Today's Date:**_____

	CIRCLE		*(If yes, explain below)
General:			
Do you have any specific concerns for today's visit?	No	Yes*	
Is your child taking any prescription medications?	No	Yes*	
Are your child's vaccines covered by your insurance plan?	No	Yes	
Is your child seeing a specialist for any ongoing medical problem(s)?	No	Yes*	
Has your child been seen in a hospital ER or treatment center since the last visit here?	No	Yes*	
Does your child have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes*	
Family Medical:			
Do the parents have any significant medical issues that we should be aware of?	No	Yes*	
Have there been any other significant family medical issues recently?	No	Yes*	
Social:			
Are the biological parents married?	No	Yes	
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*	
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*	
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*	
Symptom Review:			
Has your child had any fever (over 100.4), runny nose or significant cough in the last 3 days?	No	Yes*	
Do you have any concerns regarding your child's sleep habits?	No	Yes*	
Do you have any concerns regarding your child's behavior?	No	Yes*	
Do you notice problems with eye muscle alignment, drifting, crossing or laziness?	No	Yes*	
Does your child have ongoing eye redness or discharge?	No	Yes*	
Do you have any concerns regarding your child's hearing?	No	Yes*	
Is the child having any significant breathing problems that you are concerned about?	No	Yes*	
Has your child had episodes of vomiting recently?	No	Yes*	
Do you have any concerns regarding your child's stooling habits?	No	Yes*	
Do you have any concerns regarding the child's use of his/her legs or arms?	No	Yes*	
Do you have any concerns regarding your child's voiding/urinary habits?	No	Yes*	
Does your child have any unusual rashes that you are concerned about?	No	Yes*	

*Explain 'YES" Answers: _____

_____