



# 4 Year Pre-Visit Questionnaire

**Instructions:** Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

## General Health

1 Do you have any concerns about your child's health?	NO	YES
2 Has your child had any problems with shots or immunizations?	NO	YES
3 Does your child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES

## Feeding/Nutrition

4 Does your child eat fruits or vegetables at every meal?	YES	NO
5 Do you feed your child mostly whole grains?	YES	NO
6 Is your child drinking milk?	YES	NO
a What kind of milk?		
b How much milk per day?		
7 Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods?	NO	YES
8 Does your child drink juice or other sweetened drinks?	NO	YES
9 Do you give your child any vitamins or supplements?	NO	YES
10 Are you worried about your child's weight?	NO	YES

## Lipids

11 Does your child have parents or grandparents who had a stroke or heart attack before age 55?	NO	YES
12 Does your child have a parent with high cholesterol or on cholesterol medication?	NO	YES

**Oral Health**

13 Are cavities a problem for you or anyone in your family?	NO	YES
14 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
15 Does your child see dentist at least twice per year?	YES	NO
16 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

**Elimination**

17 Does your child have regular soft bowel movements (poop)?	YES	NO
18 Have you started toilet (potty) training?	YES	NO

**School**

19 Is your child in preschool?	YES	NO
20 Do you have any concerns about learning or school behavior?	NO	YES

**Activity/Exercise/Screen time**

21 Does your child have more than 1 hour of screen time (smartphone, tablet, TV)?	NO	YES
22 Does your child have any screen time in his/her bedroom?	NO	YES
23 Do you read to your child every day?	YES	NO
24 Do you do family activities like walking, bicycling, swimming, or dancing?	YES	NO
25 Do you do educational activities as a family, like go to libraries, museums, zoos, or on nature walks?	YES	NO
26 Do you eat meals together as a family?	YES	NO
27 Do you spend time alone with each of your children?	YES	NO
28 Does your child play actively at least 1 hour every day?	YES	NO

**Sleep**

29 Do you have any concerns about your child's sleep?	NO	YES
30 Does your child snore more than a little?	NO	YES

**Social Stressors**

31 Do you feel that you receive the support you need?	YES	NO	
32 Have there been any major changes or stresses in your family recently?	NO	YES	
33 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
34 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

**Behavior**

35 Do you have any questions about how to discipline your child?	NO	YES
36 Do you praise your child when he/she is behaving well?	YES	NO
37 Do you give your child choices?	YES	NO

**Development**

38 Does your child talk well, using long meaningful sentences?	YES	NO
39 Does your child tell simple stories and nursery rhymes?	YES	NO
40 Can other people can fully understand what your child is saying?	YES	NO
41 Does your child know his/her full name, telephone number, and 911?	YES	NO
42 Does your child make up stories, fantasies, situations?	YES	NO
43 Can your child skip or hops on one foot 4-5 times?	YES	NO
44 Does your child know 4 or more colors?	YES	NO
45 Can your child count to 10?	YES	NO
46 Can your child stack 8 or more blocks?	YES	NO
47 Can your child draw a person with head, body, arms, and legs?	YES	NO
48 Can your child copy a cross?	YES	NO
49 Can your child dress him/herself without supervision?	YES	NO

**Safety**

50 Do you talk to your child about stranger safety?	YES	NO
51 Does your child know that private parts are private?	YES	NO
52 Does your child wear a helmet when biking, skating, skiing, or snowboarding?	YES	NO
53 Does anyone smoke or vape around your child	NO	YES
54 Is there a gun in the home?	NO	YES
a If yes, is it locked or in a safe and is the ammunition stored separately?	YES	NO
55 Does your child ride in a forward-facing safety seat, in the back seat?	YES	NO
56 Do you put sunscreen on your child when outside for a long time?	YES	NO
57 Do you ever leave your child alone in the car, house, or yard?	NO	YES
58 Do you have working smoke and carbon monoxide detectors in the your home?	YES	NO
59 Do you have a home fire escape plan?	YES	NO

**Tuberculosis**

60 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
61 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
62 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
63 Has your child traveled to a high-risk country for more than a week?	NO	YES

**Review of Systems**

64 Do you have any concerns about your child's hearing?	NO	YES
65 Do you have any concerns about your child's vision?	NO	YES
66 Do you have any concerns about allergies?	NO	YES