



Woodinville Pediatrics 3 years Questionnaire

Patient Name: _____ Date: _____

Parental concerns this visit: _____

Current Medications: _____

Current Allergies: _____

Family

Parents working outside home ____mother ____father

Child Care ____yes ____no Type _____

Preschool ____yes ____no _____

Changes since last visit _____

Diet

5 servings of fruit/vegetable ____yes ____no

Limited sweetened liquids ____yes ____no

Vitamins/Supplements _____

Diet Concerns ____yes ____no

Diet comments _____

Bowel/Bladder

Stool Concerns ____yes ____no

Stool Consistency ____hard ____soft

Urination Concerns ____yes ____no

Toilet training ____yes ____in process ____no

Sleep

Sleep concerns ____yes ____no

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Physical Activity Play time (60m/d) ____yes ____no
Screen time (<2hr/d) ____yes ____no

Parent-child Interaction

Communication concerns ____yes ____no

Offer choices ____yes ____no

Cooperation concerns ____yes ____no

Development

Social Emotional: ____Self care skills

____Imaginative play

Communication: ____2-3 sentences

____Usually understandable

____Names a friend

Cognitive: ____Names objects

____Knows if boy or girl

Physical : ____Build tower (6-8 blocks)

____Stands on 1 foot

- ☐ Throws ball overhand
- ☐ Walks upstairs alternating feet
- ☐ Copies circle
- ☐ Draws person (2 body parts)
- ☐ Toilet trained during day

Additional comments: _____
