3 and 4 Year Parent Questionnaire

Children's MINNESOTA

Scan this code for age specific health information

Date:

Do you have any concerns about your child's: No | Yes hearing?

Does your child:

No | Yes eat fast food more than once a week?

No | Yes get less than 1 hour of active play per day?

Do you:

Yes | No always use a car seat? (5-point harness, in the backseat)

Yes | No have working smoke alarms and carbon monoxide detectors in your home?

Yes | No have the poison control number? (1-800-222-1222)

Yes | No put sunscreen on your child?

Yes | No help your child brush their teeth every day?

Yes | No take your child to the dentist each year?

Yes | No know how to access Pre-K screening?

Yes | No avoid foods that can cause your child to choke? (hot dogs, peanuts, popcorn, raw carrots, hard candy)

Yes | No know CPR & the rescue maneuver for choking? (www.cpr.heart.org and search CPR Anytime)

Yes | No If you own a gun, is it locked, with bullets stored separately? ☐ No gun in home

Family Medical History

No | Yes Have there been any changes to your family medical history?

No | Yes Is there a family history of early heart disease? (under age 65 for women, age 55 for men)

No | Yes Does your child have a parent with total cholesterol over 240 mg/dL?

Tuberculosis (TB) Risk

No | Yes Has your child had recent close contact with someone with active TB disease?

No | Yes Does your child have any chronic illnesses (including HIV, diabetes, cancer, kidney disease, intestinal disease)?

No | Yes Was your child born in or had extensive travel to Asia, Africa, Eastern Europe or Latin America?

No | Yes Has your child been exposed to homeless shelters, refugee camps or prison/jail?

Social Determinants of Health

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? *(check all that apply)* Z59.82

- ☐ Yes, it has kept me from medical appointments or getting medication
- ☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
- ☐ No

Would you like information regarding these concerns? *(check all that apply)*

☐ Yes, have someone contact me ☐ Yes, I would like written information ☐ No

Please write down any questions or concerns that you would like to talk about today:

_______ Provider initials

Name: ______________________

Birthdate: ______________________