3 YRS QUESTIONNAIRE

Name of Patient_____DOB_____

1. Milk_____ oz per day
2. All food groups included in diet ☐ Y ☐ N
3. Juice___oz per day
4. Regular bowel movements ☐ Y ☐ N
5. Has your baby been in contact with anybody who has active Tuberculosis ☐ Y ☐ N
6. Dental home is established with_____. Last checkup was _____.

Development is appropriate for age.

1. Speaks in 3 word sentences ☐ Y ☐ N
2. Has more than 300 word vocabulary ☐ Y ☐ N
3. Rides tricycle ☐ Y ☐ N
4. Jumps, hops ☐ Y ☐ N

Other Comments/Concerns-

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