4 Yrs Questionnaire

Name of Patient_____**DOB**_____

1. ☐Whole milk ☐2% milk ☐1% milk ☐Other_____
   How much?___oz per day
2. All food groups included in diet ☐ Y ☐N
3. Juice____oz per day ☐Diluted ☐Undiluted
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 check up was_____
7. Any developmental concerns _____
8. Sleep and behavior appropriate for age: ☐ Y ☐N

Other Comments

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