South Lake Pediatrics
Infant, Child & Adolescent Care
www.southlakepediatrics.com
952-401-8300

Parent Questionnaire for Patients (Ages 12-23 months)

Name:	Acct. No:
Age:	DOB:
Phone:	PC:
Date:	Clinician:

Parent questionnaire – Please take the time to answer the following questions **ON BOTH SIDES** in order for us to better care for your child.

Section	Question	Please Circle Answer		Counseled/Referred
Nutrition / Healthy Lifestyle	Does your child have any food, medication, or environmental allergies?	No	Yes	
	Has your child required surgery, hospitalizations, ER or urgent care visits since his/her last physical/checkup? Please circle	No	Yes	
	Have there been any changes in a family member's health since your last visit (i.e. new onset diabetes, high cholesterol, unhealthy weight, etc)?	No	Yes	
	Do you have any concerns about your child's height, weight, or development (including language, speech clarity, vision or hearing)? Please circle	No	Yes	
	Has your child started seeing a dentist yet?	Yes	No	
	Do you have well water and/or a reverse osmosis filter?	No	Yes	
	Do you and your family eat dinner together most nights?	Yes	No	
	How many servings a day does your child get of the following? Please circle Fruits 0-1 2-3 4 or more Vegetables 0-1 2-3 4 or more Dairy 0-1 2-3 4 or more Sweetened beverages (juice, soda, sports drinks) 0 1 2 or more			
	How many meals does your child eat out per week? Please circle 0 1 2 or more	No	Yes	
Social	Has there been a major change in your life recently due to moving, divorce, remarriage, new job, illness or other stressor? Please circle	No	Yes	
	Does your child attend daycare?	No	Yes	
	Do you often feel stressed anxious, angry or depressed?	No	Yes	
	Do you have any concerns regarding the use of alcohol or drugs by anyone in your family or by anyone caring for your child?	No	Yes	
Safety	Have you or any of your children ever been hurt, yelled at, threatened, or treated badly?	No	Yes	
	Do you keep handguns, rifles, BB guns, bow and arrows or other weapons in your home? Please circle	No	Yes	
	Do you have working smoke and carbon monoxide detectors in your home?	Yes	No	
	What kind of carseat does your child sit in? Please circle 1. Infant or Child 2. Rear facing or Forward facing			

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PLEASE COMPLETE BOTH SIDES

		Please Circle Answer		Counseled/Referred
Lead Exposure	Do you have working smoke and carbon monoxide detectors?	Yes	No	
	Does your child live in or regularly visit a home built before 1978 that is being remodeled or has been renovated within the last six months?	No	Yes	
	Does your child live within the city limits of Minneapolis or St. Paul?	No	Yes	
	Does your child have a brother, sister or playmate who has been diagnosed with an elevated lead level?	No	Yes	
	Has your child taken any folk medicine or home remedies? **See lead handout*	No	Yes	
	Does your child have contact with an adult who has a job or hobby that involves lead exposure? **See lead handout*	No	Yes	
TB Exposure	Has your child lived in or visited another country for more than 1 month in the past 12 months? Which country? How long? ______________________	No	Yes	
	Has your child been exposed to anyone with TB disease, or to anyone who has had a positive skin test for TB?	No	Yes	
	Does your child spend time with anyone who works, visits, or has been in jail, prison, or a homeless shelter, or who uses illegal drugs, or has HIV?	No	Yes	

☐ **Questions reviewed and safety/anticipatory guidance provided to family.**

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Clinician Initials

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PLEASE COMPLETE BOTH SIDES