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

Parent Questionnaire for Patients (Ages 2-5 years)

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.

		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, hospitalization, ER or urgent care visits since his/her last physical/checkup? **Please circle**	No	Yes	
	Do you have any concerns about your child's height, weight or development (including language, vision or hearing)? **Please circle**	No	Yes	
	Do you have well water and/or a reverse osmosis filter? **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	
	Has your child been to the dentist in the last year?	Yes	No	
	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 drinks (juice, soda, sports drink) 0 1 2 or more			
	How many meals does your child eat out per week? **Please circle** 0 1-2 3 or more			
	How many minutes of activity does your child get on an average day? **Please circle** 0-30 30-60 60 or more			
Social	Does your child attend preschool or daycare?	No	Yes	
	Is your child involved in organized activities? (swimming, dance, ECFE, etc.) Please list	Yes	No	
	How many hours of TV, computer or video game time does your child get per day? **Please circle** 0-1 2-3 3 or more			
	Is there a TV, VCR, DVD, video game or computer in your child's bedroom?	No	Yes	
	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	
	Do you feel you or your child need help with discipline and/or behavior issues?	No	Yes	
	Do you often feel stressed, anxious, angry or depressed?	No	Yes	
	Do you and your spouse/partner agree on rules?	Yes	No	
	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	
	Do you have any concerns regarding conflict or violence that your child might by exposed to?	No	Yes	

– OVER – **PLEASE COMPLETE BOTH SIDES**

		Please Circle Answer		Counseled/Referred
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 and your child always use a bike helmet when biking with you or on his/her own bicycle or tricycle?	Yes	No	
	Does your child always sit in a car seat or booster seat? **Please circle**	Yes	No	
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.** _____ Clinician Initials

– OVER –

PLEASE COMPLETE BOTH SIDES