PEDIATRIC HEALTH MAINTENANCE – 3 Years
Parent Questionnaire

General

Do you have any concerns or questions you would like to discuss today?	☐ No	☐ Yes
If yes, please specify:		
Does your child seem to hear well?	☐ Yes	☐ No
Does your child seem to see well without squinting?	☐ Yes	☐ No
Do your child's eyes ever appear to cross or drift apart?	☐ No	☐ Yes
Does your child snore most nights?	☐ No	☐ Yes
Is your child in daycare or preschool?	☐ No	☐ Yes
Does your child have more than 1 hour a day of screen time?	☐ No	☐ Yes
Has your child seen a dentist?	☐ Yes	☐ No

Diet, Sleeping, and Elimination

What type of milk does your child drink?		
How much milk does your child drink each day?		
Are you concerned about your child's weight or eating habits?	☐ No	☐ Yes
Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)?	☐ Yes	☐ No
Is your child toilet-trained for daytime?	☐ Yes	☐ No

Development

Talks with you in a conversation using at least two back-and-forth exchanges?	☐ Yes	☐ No
Asks "who," "what," "where," or "why" questions, like Where is Mommy / Daddy?	☐ Yes	☐ No
Says what action is happening in a picture or book when asked, like "running," "eating," or "playing"?	☐ Yes	☐ No
Does your child know his or her own age?	☐ Yes	☐ No
Can strangers understand your child's speech most of the time?	☐ Yes	☐ No
Does your child use pronouns such as "he," "she," or "it"?	☐ Yes	☐ No
Can your child dress himself or herself, and put on shoes?	☐ Yes	☐ No
Can your child name at least one color?	☐ Yes	☐ No

Safety

Does your child wear a helmet while riding a tricycle?	☐ Yes	☐ No
Does your child ride in a car seat in the back seat?	☐ No	☐ Yes
Are there any smokers in your home?	☐ No	☐ Yes
Do you have a firearm in your home?	☐ No	☐ Yes
If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them?	☐ Yes	☐ No
Are you afraid of your partner or anyone close to you?	☐ No	☐ Yes
Do you feel overly stressed or unsupported?	☐ No	☐ Yes

Completed by (name and relationship to patient) _____ Date (month/day/year) _____

PATIENT NAME

VIRGINIA MASON FRANCISCAN HEALTH
Pediatric Health Maintenance – 3 Years

VMMC901032 (04-2025)