Ages 1-5 Year Health Survey (2 SIDES)

Child's
Name_____

Allergies?_____

Meds?_____

Vitamins?_____

Family:
Have there been any significant change in your family life this year? (i.e. move, divorce, illness, etc)

- ☐ No
- ☐ Yes_____

School/Daycare:
Is your child in daycare/school? If yes, where/year?

- ☐ No
- ☐ Yes_____

Any concerns?

- ☐ No
- ☐ Yes_____

Developmental: Any concerns?

- ☐ No
- ☐ Yes_____

Electronics & Media: How many hours of computer/TV/video on a TYPICAL day?_____

Activities: what, if any, organized activities does your child participate in? (i.e. art, gym, music)

_____

Safety:

- ☐ Rear facing carseat (*until 2 yr AND 30 lb)*
- ☐ Front-facing carseat (*until 5 yr AND 40 lb*)
- ☐ Booster seat (*until 8 yr AND 60 lb*)

In your home do you have:
Anyone who smokes? (inside or out, any caregiver)

- ☐ Yes
- ☐ No

Smoke detectors?

- ☐ Yes
- ☐ No

Carbon Monoxide detectors?
(remember to bring to vacation homes!)

- ☐ Yes
- ☐ No

Does your child wear a helmet for biking, skiing, skating, scootering?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Not applicable

Are there any **guns** in your home?

- ☐ No
- ☐ YES- safely stored via:

_____

Is there a **pool** at your home?

- ☐ No
- ☐ Yes; there is a: O Fence O Safety cover

Do you own any animals/pets?

- ☐ No
- ☐ Yes, _____

Sleep:
Any concerns?_____

How many hours on a TYPICAL night?_____

How many naps in a TYPICAL day? _____

Bowel Movements:
Any concerns?_____

How many BMs on a typical day?_____
Is your child potty trained for:

Urine?	Yes / No
Stool?	Yes / No
Dry overnight?	Yes / No

***PLEASE COMPLETE THE SECOND SIDE →**

Nutrition:

For feeding, your child uses (can pick several):

- ☐ Breast
- ☐ Bottle
- ☐ Straw cup
- ☐ Sippy cup
- ☐ Open cup

For milk, your infant drinks:

- ☐ Breast only
- ☐ Breast + formula
- ☐ Formula only
- ☐ Whole milk

If breastfeeding, how many times per day:_____

On a **typical** day, how many servings does your child get of:

Fruit (serving = ¼ cup)_____

Vegetable (serving = ¼ cup) _____

Dairy (serving = ¼ cup, ½ oz cheese)_____

Bread/cereal/rice/pasta (serv = ¼ cup, ½ slice)_____

Fish/Egg/Red Meat or Poultry:
(1 oz meat, 2-3 tbsp beans, 1tbsp PB, 1 egg)

_____

Is your child being brought up:

- ☐ Vegan OR
- ☐ Vegetarian?

Dental:

Any dental concerns?

- ☐ NO
- ☐ YES_____

Has your child seen the dentist yet?

- ☐ NO
- ☐ YES

Does your child see the dentist twice yearly?

- ☐ NO (last seen_____)
- ☐ YES

Fluoride source:

(after 6 months of age brush any teeth with a rice sized amount of toothpaste twice a day, after age 2 use a pea sized amount- we like Toms of Maine)

- ☐ City water (home or daycare)
- ☐ Bottled fluoridated (nursery) water
- ☐ Fluoride Vitamin
- ☐ Fluoride Rinse
- ☐ None