30 Month Health Maintenance Form

Patient Name _____

Who accompanied child today?
name and relationship to child _____

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Feedings:

Does your child:

Feed himself or herself well?	Yes	No
Use a spoon or fork?	Yes	No
Drink from a cup with one hand?	Yes	No
Have any foods he/she cannot tolerate?	Yes	No

If yes, list: _____

Eat a variety of food? Yes No

If no, what does child eat? _____

Any concerns with stooling or urination? _____

Is your child showing interest in toilet training? Yes No

Sleep pattern:

Average hours of nighttime sleep: _____

Number of Naps? _____

Are there any smokers in the household? _____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Medications:

Please list current medications: _____

_____

_____

Any allergies to medicine? _____

_____

Does your child:

Jump up and down in one place?	Yes	No
Throw a ball overhand?	Yes	No
Wash and dry hands?	Yes	No
Brush teeth with help?	Yes	No
Put on clothes with help?	Yes	No
Copy a vertical line?	Yes	No
Use short phrases of three to four words?	Yes	No
Is your child understandable to others 50% of the time?	Yes	No
Know correct action of certain animals? cat meows, cow moos, bird flies	Yes	No
Point to 6 body parts?	Yes	No

If you do not understand any of these questions, please ask your nurse.