

Patient Name/Date of Birth: _____

Well Child Check: 2 year visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No Yes

Has your child had any reactions to vaccinations in the past? No Yes

Development:

Can your child kick a ball? Yes No

Can your child jump in place (jump with both feet off the ground)? Yes No

Does your child say more than 50 words? Yes No

Does your child use pronouns (I, me, you)? Yes No

Does your child understand directions? Yes No

Does your child imitate housework? Yes No

Can your child run, climb and walk up and down stairs? Yes No

Does your child know 6 or more body parts? Yes No

Is your child showing interest in potty training? Yes No

Do you and your child read together daily? Yes No

Do you have concerns about how your child hears or speaks? No Yes

Do you have any concerns about how your child sees? No Yes

Does your child hold objects close when trying to focus? No Yes

Do your child's eyes appear unusual or seem to cross, drift or be lazy? No Yes

Do your child's eyelids droop or does one eyelid tend to close? No Yes

Dental Health:

Do you help your child brush and floss his/her teeth daily? Yes No

Does your child's primary water source contain fluoride? Yes No Unsure

If no, does your child take a fluoride supplement? Yes No N/A

Does your child have a dentist? Yes No

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games, or use a smart phone or tablet? No Yes

Does your home have a working smoke detector? Yes No

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes No N/A

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If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always stay with your child when she/he is in the bathtub?	Yes	No	
Do you and your child spend time near water (pool, river or lake)?	No	Yes	
If so, is your child always safely supervised?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your child in a forward-facing car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your child?	Yes	No	
Do you always check for children before backing your car out?	Yes	No	
Does your child spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your child wear a helmet when riding a tricycle or anything with wheels?	Yes	No	N/A
Does your child spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)?	No	Yes	
Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes	
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes	
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes	
Does your child take any imported remedies or supplements?	No	Yes	

Tuberculosis Screening:

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)?	No	Yes	Unsure
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Was your child born in a high risk country (countries *other than* the US, Canada, Australia, New Zealand or Western Europe)? No Yes

Has your child traveled to, *or* had contact with people who live in, a high risk country for more than one week? (Countries *other than* the US, Canada, Australia, New Zealand or Western Europe) No Yes

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):

Did any of your child’s parents or grandparents have significant heart disease at or before 55 years of age (heart attack, stroke, angioplasty, angina or bypass surgery)? No Yes

Do either of the child’s parents have a cholesterol of 240 or higher? No Yes

Sleep:

How many hours does your child sleep at night? _____ hours

How many hours does your child nap throughout the day? _____ hours

Nutrition/Physical Activity:

Does your child drink? (circle all appropriate): [breast milk] [whole milk] [other type of milk _____]

How many ounces of milk does your child drink per day? _____ oz

How much juice does your child drink in 24 hours? _____ oz

Does your child drink from a bottle or take a pacifier? No Yes

Is your child eating fruits and vegetables at least two times per day? Yes No

Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes No

Does your child eat high fat foods such as fried foods, chips, ice cream or pizza more than once per week? No Yes

Does your child drink soda, sports drinks, energy drinks or other sweetened drinks? No Yes

Does your child eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)? Yes No

Do you ever struggle to put food on the table? No Yes

Does your child play actively most days of the week? Yes No

Do you have any concerns about your child’s weight or feeding? No Yes

Elimination:

Does your child have bowel movements on a regular basis with a normal (soft) consistency? Yes No

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Please list any medications or supplements your child is taking:

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues:

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

Signature: _____ Date: _____

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature	Print Name:			Date:	