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
### Questionnaire • Well Child Check 2 Years

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

### Risk Assessment for Lead Exposure:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child live in or regularly visit a house or child care facility built before 1950?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have a sibling or playmate who has or did have lead poisoning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child take any imported remedies or supplements?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tuberculosis Screening:

Was your child born in a country with an elevated TB rate?  No Yes

This includes all countries other than the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate for one month or more? (Countries other than those listed above)  No Yes

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection?  No Yes Unsure

Is your child immunosuppressed (currently or planned)?  No Yes

This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

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

If yes, who? at what age?

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

If yes, who? at what age?

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 junk foods such as chips, fries, ice cream or fast food more than twice 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 have trouble affording to buy food for your family?

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

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?

__________________________________________________________________________

Parent or Guardian Signature:  _____________________________________________

Date:  __________________________

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Counselled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Tobacco Exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Physical Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Dental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PCP’s Signature  Print Name:  Date:  

Patient Declined the SHA

Ver.12-12-17

L15862  (04/18)