## Well Child Check: 2 1/2 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:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Can your child throw a ball overhand?</td>
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<td>Can your child jump in place (jump with both feet off the ground)?</td>
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<td>Does your child say more than 150 words?</td>
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<td>Does your child use pronouns (I, me, you)?</td>
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<td>Is your child’s speech at least 50% understandable to a most people?</td>
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<td>Does your child understand directions?</td>
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<td>Does your child imitate housework?</td>
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<td>Can your child run, climb and walk up and down stairs?</td>
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<td>Is your child showing interest in potty training?</td>
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<td>Do you and your child read together daily?</td>
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<td>Do you have any concerns about how your child sees?</td>
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<td>Do your child’s eyes appear unusual or seem to cross, drift or be lazy?</td>
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<tr>
<td>Do your child’s eyelids droop or does one eyelid tend to close?</td>
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<tr>
<td>Do you have concerns about how your child hears?</td>
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<tr>
<td>Do you have concerns about how your child speaks?</td>
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### Dental Health:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Do you help your child brush and floss his/her teeth daily?</td>
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<td>Does your child’s primary water source contain fluoride?</td>
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<td>If no, does your child take a fluoride supplement?</td>
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<td>Does your child have a dentist?</td>
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### Staying Healthy/Safety/Tobacco Exposure:

<table>
<thead>
<tr>
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<th>Yes</th>
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<tbody>
<tr>
<td>Does your child watch TV, play video games, or use a smart phone or tablet?</td>
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<td>Does your home have a working smoke detector?</td>
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Have you turned your water temperature down to low-warm (less than 120 degrees)?

Yes  No  N/A

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 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

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**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:
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)?  
This includes HIV infection, organ transplant recipient, other immune  
system problems, or treatment with immunosuppressive medications.  
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
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? ________________ How high (before treatment)? ________________

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:
What type of milk do you give your child? (circle one) [Whole] [2%] [Nonfat] [Other]  

How many ounces of milk does your child drink per day  
____ oz
How much juice does your child drink in 24 hours?  
____ oz

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 normal (soft) bowel movements on a regular basis? 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: ___________________________

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<tr>
<td>Physical Activity</td>
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<td>Dental Health</td>
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**Comments:** __________________________________________________________________________

[ ] Patient Declined the SHA

PCP’s Signature ____________
Print Name: ____________
Date: ____________