Lucile Packard Children's Hospital

Stanford Lucile Salter Packard Children's Hospital

Children's Health

Stanford

STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304

Date of Birth

Patient Name

## Well Child Check: 2 year visit questionnaire

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## **Interval History:**

your last appointment in the office?NoYesHas your child had any reactions to vaccinations in the past?NoYesDevelopment:YesNoCan your child kick a ball?YesNoCan your child six a ponce than 50 words?YesNoDoes your child say more than 50 words?YesNoDoes your child use pronouns (1, me, you)?YesNoDoes your child understand directions?YesNoDoes your child understand directions?YesNoDoes your child nuck of on more body parts?YesNoDo you child showing interest in potty training?YesNoDo you have concerns about how your child hears or speaks?NoYesDo you child hold objects close when trying to focus?NoYesDo your child's eyes appear unusual or seem to cross, drift or be lazy?NoYesDo your child's eyes appear unusual or seem to cross, drift or be lazy?NoYesDo you child's eyend dinders in/her teeth daily?YesNoYesDo you child's primary water source contain fluoride?YesNoNaDo sour child's primary water source contain fluoride?YesNoNaDo sour child have a dentist?YesNoYesDo sour child have a dentist?YesNoYesDo your child house and floss his/her teeth daily?YesNoYesDo your child bush and floss his/her teeth daily?YesNoYesDoes your child have a dentist?YesNo </th <th>Has your child had any major illnesses, ER or Urgent Care trips since</th> <th></th> <th></th> <th></th>	Has your child had any major illnesses, ER or Urgent Care trips since			
Development: Can your child kick a ball?YesNoCan your child jump in place (jump with both feet off the ground)?YesNoDoes your child say more than 50 words?YesNoDoes your child say more than 50 words?YesNoDoes your child understand directions?YesNoDoes your child understand directions?YesNoDoes your child run, climb and walk up and down stairs?YesNoDoes your child run, climb and walk up and down stairs?YesNoDoes your child know 6 or more body parts?YesNoDo you and your child read together daily?YesNoDo you and your child read together daily?YesNoDo you have concerns about how your child sees?NoYesDo your child's eyelids droop or does one eyelid tend to close?NoYesDo your child's eyelids droop or does one eyelid tend to close?NoYesDo you halve sourc contain fluoride?YesNoNoDo sou nchild's eyelids droop or does one eyelid tend to close?NoYesDo you rchild's primary water source contain fluoride?YesNoNi/ADoes your child have a dentist?YesNoNi/ADoes your child have a dentist?YesNoNi/ADoes your child have a dentist?YesNoNi/ADoes your child have a working smoke detector?YesNoYesDoes your child have a working smoke detector?YesNoYesDoes your child watch TV, play	your last appointment in the office?	No	Yes	
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Does your child watch TV, play video games, or use a smart phone or tablet?NoYesDoes your home have a working smoke detector?YesNoHave you turned your water temperature down to low-warmYesYes	Does your child have a dentist?	Yes	No	
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Does your home have a working smoke detector?YesNoHave you turned your water temperature down to low-warm	Does your child watch TV, play video games, or use			
Have you turned your water temperature down to low-warm	a smart phone or tablet?	No	Yes	
	Does your home have a working smoke detector?	Yes	No	
(less than 120 degrees)? Yes No N/A	Have you turned your water temperature down to low-warm			
	(less than 120 degrees)?	Yes	No	N/A

Stanford <u>Jocile Salter Packard Children's Hospital</u> TANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304 Questionnaire • Well Child Check 2 Years	)		
Page 2 of 4 Date of Birth			
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	
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	

Stanford <u>ucile Salter Packard Children's Hospital</u> STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304 P	Patient Name
Questionnaire • Well Child Check 2 Years Page 3 of 4 D	Date of Birth
Tuberculosis Screening:	
Was your child born in a country with an elevated TB rate? This includes all countries <i>other than</i> the United States, Canada, Australia, New Zealand, or countries in western or northern Europ	
Has your child visited or lived in a country with an elevated TB rate <i>for one month or more</i> ? (Countries other than those listed above	e) No Yes
Has your child had contact with someone (including family member, provider, or other caretaker) with known TB infection, or who h treated for TB infection?	
Is your child immunosuppressed (currently or planned)? This includes HIV infection, organ transplant recipient, other immussive medication of the system problems, or treatment with immunosuppressive medication.	
<b>Risk Assessment for Abnormal Lipid Profile (such as high choles</b> Did any of your child's parents or grandparents have significant hear	rt
disease at or before 55 years of age (heart attack, stroke, ang	
angina or bypass surgery)? If yes, who?	No Yes
Do either of the child's parents have a cholesterol of 240 or higher? If yes, who?	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	e milk] [other type of milk]
How many ounces of milk does your child drink per day?	0Z
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

Stanford Children's Health Lucile Packard Children's Hospital Stanford Lucile Salter Packard Children's Hospital STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304 Questionnaire • Well Child Check 2 Years Page 4 of 4	Patient Name		
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 provider?	y other concer	n you wo	ould like to discuss with your
Parent or Guardian Signature:			
	<b>Fellow</b>	Contract	
Clinic Use Only Counseled Referred Anticipatory Guidance	Follow-up Ordered	Comme	1115.
Nutrition			
Safety			
<ul> <li>Physical Activity</li> <li>Dental Health</li> </ul>		🗆 Pat	ient Declined the SHA
PCP's Signature Print Name:		Date:	