2 Year Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1. Do you have any concerns about your child's health?	NO	YES
2. Any problems with previous immunizations?	NO	YES

Feeding/Nutrition

3. Is your child taking milk?	YES	NO
a. What type of milk?		
b. How many ounces per day?		
4. Does your child have fruits or vegetables at every meal?	YES	NO
5. Giving your child mostly whole grains?	YES	NO
6. Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
7. Avoiding choking hazard foods (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
8. Is your child drinking from a bottle?	NO	YES
9. Does your child drink juice or other sweetened drinks?	NO	YES
10. Giving any vitamins or supplements?	YES	NO

Lipids

11. Parents or grandparents with stroke or heart attack before age 55?	NO	YES
12. Parent with high cholesterol or on cholesterol medication?	NO	YES

Oral Health

13. Are cavities a problem for you or anyone in your family?	NO	YES
14. Are you using a soft toothbrush or cloth to clean your child's teeth two times per day?	YES	NO
15. Do you have a dentist for your child?	YES	NO
16. Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

17. Child has a daily, soft bowel movement (poop)?	YES	NO
18. Have you started toilet training?	YES	NO
19. Does your child tell you when a diaper needs to be changed?	YES	NO

Activity/Exercise/Screen time

20. Does your child watch TV?	NO	YES
21. Is there a TV in your child's bedroom?	NO	YES
22. Do you read to your child every day?	YES	NO

Sleep

23. Does your child sleep through the night?	YES	NO
24. Do you have a bedtime routine?	YES	NO
25. Does your child fall asleep on his own in his own bed?	YES	NO
26. Does your child snore more than a little?	NO	YES

Social Stressors

27. Are you able to take some time for yourself?	YES	NO
28. Any major changes or stresses in your family recently?	NO	YES
29. Do you ever worry your family will go hungry?	NO	YES
30. Do you have daycare concerns?	NO	YES

Behavior

31. Excessive tantrums?	NO	YES
32. Questions about discipline?	NO	YES
33. Do you praise your child when he/she is behaving well?	YES	NO
34. Do you give your child choices?	YES	NO

Development

35. Has a fifty word vocabulary?	YES	NO
36. Speaks in two to three word phrases (“More milk” or “Hi mom”)?	YES	NO
37. Knows six or more body parts?	YES	NO
38. Copies things that you do?	YES	NO
39. Carries out two-step commands?	YES	NO
40. Walks up and down stairs while holding on?	YES	NO
41. Turns pages one at a time?	YES	NO
42. Can name some pictures in books?	YES	NO
43. Holds a cup with one hand?	YES	NO
44. Jumps with both feet off the floor?	YES	NO
45. Throws a ball overhand?	YES	NO
46. Kicks a ball?	YES	NO
47. Tries to write with a pencil?	YES	NO

Lead

48. Regularly spends time in a house built before 1978?	NO	YES
a. Any peeling or chipping paint?	NO	YES
b. Any recent, ongoing or planned remodeling?	NO	YES
49. Has a sibling or playmate who ever had lead poisoning?	NO	YES

Safety

50. Crib mattress at the lowest position?	YES	NO
51. Do you watch your child when she plays outside?	YES	NO
52. Do you keep your child away from vehicles, lawn mowers, driveways, and streets?	YES	NO
53. Wears a helmet when on a tricycle or bicycle?	YES	NO
54. Is your child exposed to anyone who smokes?	NO	YES
55. Is there a gun in the home? a. Is it locked or in a safe?	NO	YES
56. Child rides in a forward-facing safety seat, in the back seat?	YES	NO
57. Using sunscreen for prolonged sun exposure?	YES	NO
58. Do you have the number for Poison Control?	YES	NO

Tuberculosis

59. Has a family member or contact had tuberculosis disease?	NO	YES
60. Has a family member had a positive TB skin test (PPD)?	NO	YES
61. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES

62. Has your child traveled to a high-risk country for more than a week?	NO	YES

Review of Systems

63. Any concerns about your child’s hearing?	NO	YES
64. Any concerns about your child’s vision?	NO	YES