2 Years – well child care Patient Name:_____D.O.B_____

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? _____

Does your child attend daycare?_____ ▢ Yes ▢No

Development

Points to things in a book when you ask, for example "Where is the bear?"_____ ▢ Yes ▢No
Says at least 2 words together, like "More milk."_____ ▢ Yes ▢No
Points to at least 2 body parts when you ask them to show you_____ ▢ Yes ▢No
Uses more gestures than just waving or pointing, like blowing a kiss or nodding yes_____ ▢ Yes ▢No
Kicks a ball_____ ▢ Yes ▢No
Runs_____ ▢ Yes ▢No
Walks (not climbs) up a few stairs with or without help_____ ▢ Yes ▢No
Eats with a spoon_____ ▢ Yes ▢No
Holds something in 1 hand while using the other hand, for example holding a container and taking the lid off_____ ▢ Yes ▢No
Tries to use switches, knobs or buttons on a toy_____ ▢ Yes ▢No
Plays with more than 1 toy at the same time, like putting toy food on a toy plate_____ ▢ Yes ▢No
Notices when others are hurt or upset, like pausing or looking sad when someone is crying_____ ▢ Yes ▢No
Looks at your face to see how to react to a new situation_____ ▢ Yes ▢No

Nutrition

Does your child drink milk? If so what kind_____ ▢Whole Milk ▢Soy Milk ▢Other _____
Do they drink approximately 16oz (480ml) per day ? _____ ▢ Yes ▢No
Avoiding excess added sugars (juice, candy, sweets) and animal fats?_ ▢ Yes ▢No
Consuming green vegetables?_____ ▢ Yes ▢No

Bowel habits

How many stools does you child have per day? _____
What do the stools look like (soft, formed, hard)? _____
Is your child showing interest in toilet training?_____ ▢ Yes ▢No

Sleep Pattern

Sleeps through the night in own crib?_____ ▢ Yes ▢No

Safety

Is your child's car seat rear facing and in the back seat?_____ ▢ Yes ▢No
Is your child exposed to tobacco smoke?_____ ▢ Yes ▢No
Are there any improperly stored firearms in the home?_____ ▢ Yes ▢No
Is the home childproofed?_____ ▢ Yes ▢No
Is the hot water temperature set low enough to prevent accidental burns?_____ ▢ Yes ▢No
Are there working smoke detectors in the home?_____ ▢ Yes ▢No

Please share any concerns that you have about your child here:

_____

_____

_____

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Please complete both sides of this form