

**30 Months - 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**

Says about 50 words \_\_\_\_\_  Yes  No

Says at least 2 words together, with one action word, like "Doggie run." \_\_\_\_\_  Yes  No

Names things in a book when you point and ask "What is this?" \_\_\_\_\_  Yes  No

Says words like I, me, or we \_\_\_\_\_  Yes  No

Shows simple problem-solving skills, like standing on a small stool to reach something \_\_\_\_\_  Yes  No

Follows 2-step instructions, for example, "Put the toy down and close the door." \_\_\_\_\_  Yes  No

Knows at least 1 color, like pointing to a red crayon when you ask, "Which one is red?" \_\_\_\_\_  Yes  No

Uses hands to twist things, like turning doorknobs or unscrewing lids \_\_\_\_\_  Yes  No

Takes some clothes off by themselves, like loose pants or an open jacket \_\_\_\_\_  Yes  No

Jumps off the ground with both feet \_\_\_\_\_  Yes  No

Turns book pages, one at a time, when you read to them \_\_\_\_\_  Yes  No

Plays next to other children and sometimes plays with them \_\_\_\_\_  Yes  No

Shows you what they can do by saying "Look at me!" \_\_\_\_\_  Yes  No

Follows simple routines when told, like helping to pick up toys when you \_\_\_\_\_  Yes  No  
say "It's clean-up time"

**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 your child have per day? \_\_\_\_\_

What do the stools look like (soft, formed, hard)? \_\_\_\_\_

Is your child showing interest in or has completed toilet training? \_\_\_\_\_  Yes  No

**Sleep Pattern**

Sleeps through the night in their own crib or bed? \_\_\_\_\_  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:**

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*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?

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**Below this line is for Office Use:**

Weight \_\_\_\_\_

Height \_\_\_\_\_

Head Circumference \_\_\_\_\_

***Please complete both sides of this form***