OBERLIN ROAD PEDIATRICS

Well Child Check: 2 Year Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes:_____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does you baby see any specialists outside of ORP? □ No □ Yes: _____

Dental Health:

Does your child have a dentist? □ Yes □ No (see our website)

Does your water source contain fluoride? □ Yes (=city water) □ No (=well water)

Is your child completely off the bottle? □ Yes □ No

Are you brushing your child's teeth with fluoridated toothpaste 2x a day? □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis result? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe) □ No □Yes

Lipid Screen:

Does your child have parents, grandparents, or aunts/uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)? □ No □ Yes

Do either of your child's PARENTS have a cholesterol level of 240+? Or is taking cholesterol medications? □ No □ Yes

Nutrition:

What type(s) of milk is your child usually drinking? □ Whole milk □ Breast milk □ Other_____

Are they usually getting 2-3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of milk a day? □ No □ Yes

Are they eating iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □ No

Developmental Questions: Does your child….

Notice when others are hurt or upset, like pausing or looking sad when someone is crying?	Yes	No
Look at your face to see how to react in a new situation?	Yes	No
Point to things in a book when you ask, for example "Where is the bear?"?	Yes	No
Say at least 2 words together like "more milk"?	Yes	No
Point 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	No

Hold something in one hand while using the other hand, ex. Holding a container and taking the lid off?	Yes	No
Try to use switches, knobs or buttons on a toy?	Yes	No
Play with >1 toy at a time? ex. putting toy food on a toy plate	Yes	No
Kick a ball?	Yes	No
Run?	Yes	No
Walk (not climb) up a few stairs with or without help?	Yes	No
Eat with a spoon?	Yes	No

Who takes care of your child during the day? _____
Are parents: single married divorced separated
Have there been major changes lately in your baby's or family's life? _____
Will your child travel internationally in the next year? If yes, where and when? _____

Does your child have ways to tell you what he wants?	Yes	No
Do you read/sing/talk with your child about what you are seeing and doing?	Yes	No
Do you use simple words to tell your child what to do?	Yes	No
Do you read to your child or look at books together every day?	Yes	No
Do you encourage caretakers to be consistent, patient and calm with your child?	Yes	No
Do you show your child how to be physically active every day by playing with them?	Yes	No
Does your child play with other children?	Yes	No
How much time every day does your child spend watching devices/screens? _____		
Do you offer your child a variety of foods including vegetables, fruits, and proteins?	Yes	No
Do you let your child decide what to eat and how much?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes

Is your child interested in using the toilet/potty chair?	Yes	No
Does your child tell you when they have had a bowel movement (poop)?	Yes	No
Is your child dry for about 2 hours at a time?	Yes	No
Does your child know the difference between being wet and dry?	Yes	No

Is your child in a rear-facing car seat in the back seat of the car?	Yes	No
Does everyone use a lap/shoulder seat belt, booster seat, or car seat?	Yes	No
Does your child wear a helmet when they ride a tricycle, in a towed bike trailer, or in a seat on an adult's bike?	Yes	No
Do you keep your child away from moving machines, lawn mowers, driveway, stairs?	Yes	No
If you have a pool (or hot tub/spa/pond), does it have a locked gate?	Yes	No
Does your child spend time in a place with an unlocked gun?	No	Yes

Do you feel safe in your home?	Yes	No
Has your partner or another significant person in your life ever hurt you or your child?	No	Yes
Do you have the things you need to take care of your child?	Yes	No
Does your home have enough heat/AC, hot water, electricity?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out?	No	Yes
Do you or other family members use marijuana, cocaine, pain pills or narcotics?	No	Yes