OBERLIN ROAD PEDIATRICS

Well Child Check: 2 Year Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Does your child walk up stairs?	Yes	No	
Can your child jump in place?	Yes	No	
Can your child make a stack of blocks?	Yes	No	
Can your child brush his/her teeth with your help?	Yes	No	
Does your child use a spoon and cup well?	Yes	No	
Does your child do pretend play using toys?	Yes	No	
Does your child scribble?	Yes	No	
Does your child climb to get objects?	Yes	No	
Does your child respond to two part commands?	Yes	No	
For example: ("Please get the book and also get your shoes.")			
Does your child use at least 20 words?	Yes	No	
Does your child combine 2 or more words?	Yes	No	

Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	
How many ounces of milk does your child drink in 24 hours? _____oz.	Whole	2 %	1 %
Is your child completely weaned from the bottle?	Yes	No	
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	

Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	
Does your tap water contain fluoride? City water contains fluoride?	Yes	No	
Do you brush your child's teeth 2 x day with fluoridated toothpaste?	Yes	No	

Do you read to your child regularly?	Yes	No	
Does your child typically watch MORE than 1 hour of			
TV/Computer/Video games, etc. daily?	Yes	No	
Have you started toilet training?	Yes	No	
Is your home child-proofed?	Yes	No	
Do you usually protect your child with sunscreen/hats/			
other measures when outdoors?	Yes	No	
Does your child have access to a pool that does not have a locked gate?	No	Yes	

Have there been any changes in your family since last visit?

_____

Who provides day time care for your child?

_____

Is your child on any medications or supplements, including fluoride or vitamins? If so, please list below:

_____

Do you have any international travel plans prior to your child's third birthday? If so, when and where?

_____

CONTINUES ON OTHER SIDE

OBERLIN ROAD PEDIATRICS

Well Child Check: 2 Year Visit

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	No	Yes	
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes	
Was your child born in a high-risk country (Countries other than the United States,Canada, Australia, New Zealand, or western European countries)?	No	Yes	
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States,Canada, Australia, New Zealand, or western European countries)?	No	Yes	

Risk Assessment for Elevated Cholesterol:

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)?	No	Yes	
Do either of the child's parents have a cholesterol level of 240 or higher?	No	Yes	

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? If so, please describe?

_____

_____

_____

_____

Questions about hearing? No Yes

Or vision? No Yes