



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.

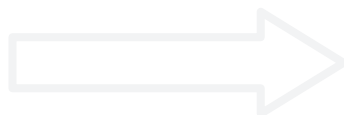
Does your child walk up stairs?	Yes	No	Unsure
Can your child jump in place?	Yes	No	Unsure
Can your child make a stack of blocks?	Yes	No	Unsure
Can your child brush his/her teeth with your help?	Yes	No	Unsure
Does your child use a spoon and cup well?	Yes	No	Unsure
Does your child do pretend play using toys?	Yes	No	Unsure
Does your child scribble?	Yes	No	Unsure
Does your child climb to get objects?	Yes	No	Unsure
Does your child respond to two part commands?	Yes	No	Unsure
For example: ("Please get the book and also get your shoes.")			
Does your child use at least 20 words?	Yes	No	Unsure
Does your child combine 2 or more words?	Yes	No	Unsure
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Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
How many ounces of milk does your child drink in 24 hours? _____ oz.	Whole	Low fat	Non fat
Is your child completely weaned from the bottle?	Yes	No	Unsure
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	Unsure
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Does your child see a dentist at least once a year (every 6 months is best)?	Yes	No	Unsure
Does your tap water contain fluoride? City water contains fluoride?	Yes	No	Unsure
Do you brush your child's teeth 2 x day with fluoridated toothpaste?	Yes	No	Unsure
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Do you read to your child regularly?	Yes	No	Unsure
Does your child typically watch MORE than 1 hour of TV/ Computer/Video games, etc. daily?	No	Yes	Unsure
Have you started toilet training?	Yes	No	Unsure
Is your home child-proofed?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/ other measures when outdoors?	Yes	No	Unsure
Does your child have access to a pool that does not have a locked gate?	No	Yes	Unsure

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?



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Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	No	Yes	Unsure
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes	Unsure
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	Unsure
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	Unsure

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	Unsure
Do either of the child's parents have a cholesterol level of 240 or higher?	No	Yes	Unsure

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?

No Yes Unsure

Questions about hearing? No Yes

Or vision? No Yes

