Patient Name:

Date of Birth:

Well Child Check: 2 1/2 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No ☐ Yes ☐
Has your child had any reactions to vaccinations in the past? No ☐ Yes ☐

Development: Can/Does your child (check all that apply) –

☐ throw a ball overhand?
☐ jump in place (both feet off the ground)?
☐ run? ☐ climb? ☐ walk up/down stairs?
☐ talk and be at least 50% understandable to a stranger?
☐ say more than 150 words?
☐ use pronouns (I, you, me)?
☐ show interest in potty training?
☐ understand directions?

Do you and your child read together daily? Yes☐ No☐
Who provides daytime care for your child? _____

Nutrition/Elimination/Physical Activity:

What type of milk does your child drink? _____ How much per day? _____ cups
How much yogurt per day? _____ How much cheese per day? _____
What dietary restrictions does your child have, if any? _____
Is your child eating 4 servings per day of a variety of fruits and vegetables? Yes☐ No☐
Does your child eat iron-rich foods (meat, iron-fortified cereal, or beans)? Yes☐ No☐
How much juice or sweet beverages does your child drink in a day? _____ oz
Does your child eat junk/fast food more than twice per week? No ☐ Yes ☐
Are there any problems with pooping or peeing? No ☐ Yes ☐
Does your child play actively most days of the week? Yes☐ No☐
Your child's medications/vitamins/supplements: _____

Dental Health:

Does your child see a dentist every 6 months? Yes☐ No☐
Does your child (with your help) brush his/her teeth daily? Yes☐ No☐

Sleep:

How long does your child sleep at night? ____ hours
How long does your child nap? ____ hours

Staying Healthy/Safety:

Does your child get any screen time? No ☐ Yes ☐
Does your home have a working smoke detector? Yes☐ No☐
Is your water temperature set to less than 120 degrees? Yes☐ No☐ N/A ☐
Is your child always supervised when near water, including the bathtub? Yes☐ No☐
Do you have safety guards on upper floor windows and gates for the stairs? Yes☐ No☐ N/A ☐
Does your home have cleaning supplies/medicines/matches locked away? Yes☐ No☐
Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes☐ No☐
Does your child use sun protection when outdoors? Yes☐ No☐

Is your car seat appropriately sized and in the back seat?	Yes ☐	No ☐	
Do you always check for children before backing your car out?	Yes ☐	No ☐	
Does your child wear a helmet when riding anything with wheels?	Yes ☐	No ☐	N/A ☐
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes ☐	No ☐	N/A ☐
Does your baby spend time with anyone who smokes or vapes?	No ☐	Yes ☐	

Please list any new major family medical issues:

_____

Who lives in the home with your child?

_____

What international travel has your child had since their last well check? (where and how long)

_____

What plans are there for international travel with your child in the next 12 months? (where and how long)

_____

What concerns would you like to discuss today?

_____