Well Child Check:
2 Year Visit

Child's Name: ______________________ DOB: ______________ Date: ______________

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 the 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? For example “Please get the book and also get your shoes”	YES	NO	UNSURE
Does your child use at least 20 words?	YES	NO	UNSURE
Does your child combine 2 or more words?	YES	NO	UNSURE
Does your child usually drink more than 4 oz of juice or sweetened drinks daily?	YES	NO	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, pork)?	YES	NO	UNSURE
Do you read to your child regularly?	YES	NO	UNSURE
Does your child typically watch MORE than 2 hours of TV, computer/video games, etc, daily?	YES	NO	UNSURE
Have you started toilet training?	YES	NO	UNSURE

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Question			
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 see a dentist at least once a year (every 6 months is best)?	YES	NO	UNSURE
Does your tap water contain fluoride?	YES	NO	UNSURE
Are there guns at your home, or any home your child regularly visits?	YES	NO	UNSURE
Does your child have access to a pool that does not have a locked gate?	YES	NO	UNSURE
Do you have any other safety concerns at your home? If so, please describe:			
Who provides daytime care for your child?			
Is your child on any medications or supplements including 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?			
Risk Assessment for Lead Exposures:			
Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds?	YES	NO	UNSURE
Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint inside on outside the home?	YES	NO	UNSURE
Does your child have a sibling or playmate who has or did have lead poisoning?	YES	NO	UNSURE
Does your family use any of the following IMPORTED items: pottery for cooking or storing food, home remedies, dietary/herbal supplements, candy, or eyeliner, (Kohl, Azarcon, Pay-loo-ah or others?) if YES, please specify.			