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
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 Nonfat
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
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? 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 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? No Yes Unsure
Does your child have access to a pool that does not have a locked gate? No Yes Unsure
Do you have any other safety concerns at your home? If so, please describe: ____________________________________________________________

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? ____________________________________________________________
Well Child Check: 2 Year Visit

**RISK ASSESSMENT FOR LEAD EXPOSURE:**
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 or 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, Greta, Azarcon,Pay-loo-ah or others)? IF YES, please specify.
_______________________________________________________________________________________
_______________________________________________________________________________________

**Risk Assessment for Tuberculosis Exposure/Infection:**
Has a family member or contact had tuberculosis disease?  
Yes  No  Unsure

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

Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?  
Yes  No  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)?  
Yes  No  Unsure

**Risk Assessment for Abnormal Lipid Profile (such as high 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)?  
Yes  No  Unsure

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

May 2015
### Modified Checklist for Autism in Toddlers (M-CHAT)

Please fill out the following about your child's behavior. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

<table>
<thead>
<tr>
<th>Question</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your child enjoy being swung or bounced on your knee?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. Does your child take an interest in other children?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. Does your child like climbing on things, such as up stairs?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6. Does your child ever use his or her index finger to point and ask for something?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7. Does your child ever use his or her index finger to point and indicate interest in something?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling or dropping them?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9. Does your child ever bring objects over to you to show you something?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10. Does your child look you in the eye for more than a second or two?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>11. Does your child ever seem oversensitive to noise (e.g., plugging ears)?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>12. Does your child smile in response to your face or your smile?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>13. Does your child imitate you? (You make a face; will your child imitate it?)</td>
<td>O</td>
<td>O</td>
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<tr>
<td>14. Does your child respond to his or her name when you call?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>15. If you point at a toy across the room, does your child look at it?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>16. Does your child walk?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>17. Does your child look at things you are looking at?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>18. Does your child make unusual finger movements near his or her face?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>19. Does your child try to attract your attention to his or her own activity?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>20. Have you ever wondered if your child is deaf?</td>
<td>O</td>
<td>O</td>
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<tr>
<td>22. Does your child sometimes stare at nothing or wander with no purpose?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23. Does your child look at your face to check your reaction when faced with something unfamiliar?</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>