CHILDREN FIRST
DUMFRIES 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	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?	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?

_____

CONTINUES ON OTHER SIDE

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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.	Yes	No	Unsure

_____

_____

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?	Yes	No	

_____

_____

CONTINUES ON OTHER SIDE

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DUMFRIES PEDIATRICS

Well Child Check: 2 Year Visit

Your Child's Name: _____

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 are (e.g., you've seen it once or twice), please answer as if the child does not do it.

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