

2 Year Well Child Check

Name _____

Allergies _____ Current Meds _____

Is your child healthy? Yes No _____

Has your child had any recent illness? No Yes _____

Has your child had any recent injuries? No Yes _____

Is your child off the bottle? Yes No _____

Does your child have any feeding problems? No Yes _____

Does your child take a vitamin or supplement? Yes No

Is there Fluoride in your drinking water? (city water=yes) Yes No

Does your family eat a well-rounded diet? Yes No

Does your child eat a balanced diet? Yes No _____

Does your child have any problem with stooling? No Yes _____

Does your child have any problem with urinating? No Yes

Has there been any recent change to your family structure? No Yes _____

Does your home have a safe, adequate heat source? Yes No _____

Does anyone in your household smoke? No Yes

Is your child in childcare? No Yes _____

Are you familiar with the 5-3-2-1-0 Healthy Lifestyles? Yes No

Do you have concerns about behavior or discipline? No Yes _____

Are there any unsecured firearms in the house? No Yes _____

Is your child an excessively picky eater? No Yes _____

Do you have mealtime battles? No Yes _____

Do you have any other concerns? _____

Lead Screening

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|---|----|-----|
| 1. Does your child live in or regularly visit a home or apartment built before 1950? | No | Yes |
| 2. Does your child live in or regularly visit a home or apartment that is being remodeled that was built before 1978? | No | Yes |
| 3. Is there an adult in the home whose job or hobby exposes them to lead?
(Examples: construction, painting, radiator repair, fishing, pottery, stained glass) | No | Yes |
| 4. Does your child have a brother, or sister or friend who has a history of lead-poisoning? | No | Yes |
| 5. Has your child been given any home remedies that may contain lead?
Examples: azarcon, rueda, coral, Maria Luisa, alarcon, liga, albayalde, greta, pay-loo-ah, ghasard, bala goli, kandu or kohli) | No | Yes |
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Development (Do not complete if given the Ages and Stages Questionnaire)

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|--|-----|----|
| Does your child walk up and down stairs? | Yes | No |
| Does your child walk backwards? | Yes | No |
| Does your child kick a ball? | Yes | No |
| Does your child stack 5-6 blocks? | Yes | No |
| Does your child say at least 20 words? | Yes | No |
| Does your child know his/her name? | Yes | No |
| Does your child draw a line? | Yes | No |
| Does your child help take off his/her clothes? | Yes | No |
| Does your child follow 2-step commands? | Yes | No |
| Does your child point to a named body part? | Yes | No |
| Does your child imitate housework? | Yes | No |
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