code: PD006.a

{Office Name} Previsit Questionnaire

2 Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all of the questions. Thank you.

First Name _____ **Last Name** _____ **Date of Birth** _____

What would you like to talk about today?

_____

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Talking Child

- ☐ How your child talks
- ☐ Reading together

How Your Child Behaves

- ☐ Praising your child
- ☐ Helping your child express feelings
- ☐ Knowing how to give your child limited choices
- ☐ Playing with others
- ☐ Helping your child follow directions
- ☐ Your child's weight

Toilet Training

- ☐ Signs your child is ready to potty train
- ☐ Helping your child potty train

Your Child and TV

- ☐ How much TV is too much TV
- ☐ Learning activities other than TV
- ☐ How to be physically active as a family

Safety

- ☐ Car safety seats
- ☐ Bike helmets
- ☐ Being safe outside
- ☐ Gun safety

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, please describe:

_____

Hearing - Do you have concerns about how your child hears?

- [ ] Yes
- [ ] No
- [ ] Unsure

Hearing - Do you have concerns about how your child speaks?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do you have concerns about how your child sees?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Does your child hold objects close when trying to focus?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do your child's eyes appear unusual or seem to cross, drift, or be lazy?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do your child's eyelids droop or does one eyelid tend to close?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Have your child's eyes ever been injured?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child have a sibling or playmate who has or had lead poisoning?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months)renovated or remodeled?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child live in or regularly visit a house or child care facility built before 1950?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Has a family member or contact had tuberculosis or a positive tuberculin skin test?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Is your child infected with HIV?

- [ ] Yes
- [ ] No
- [ ] Unsure

Dyslipidemia - Does your child have parents or grandparents who have had a stroke or heart problem before age 55?

- [ ] Yes
- [ ] No
- [ ] Unsure

Dyslipidemia - Does your child have a parent with elevated blood cholesterol (240mg/dL or higher) or who is taking cholesterol medication?

- [ ] Yes
- [ ] No
- [ ] Unsure

Anemia - Do you ever struggle to put food on the table?

- [ ] Yes
- [ ] No
- [ ] Unsure

Anemia - Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?

- [ ] Yes
- [ ] No
- [ ] Unsure

Oral Health - Does your child have a dentist?

- [ ] Yes
- [ ] No
- [ ] Unsure

Oral Health - Does your child's primary water source contain fluoride?

- [ ] Yes
- [ ] No
- [ ] Unsure

Does your child have any special health care needs?

- [ ] Yes
- [ ] No

If yes, please describe:

_____

Have there been any major changes in your family lately?

- [ ] Move
- [ ] Job change
- [ ] Separation
- [ ] Divorce
- [ ] Death in the family
- [ ] Any other changes?

Please describe any other changes:

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke?

- [ ] Yes
- [ ] No

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning, or behavior?

- [ ] Yes
- [ ] No

If yes, please describe:

_____

Check off each of the tasks that your child is able to do:

- [ ] Stacks 5 or 6 small blocks
- [ ] Kicks a ball
- [ ] Walks up and down stairs 1 step at a time alone while holding wall or railing
- [ ] Can point to at least 2 pictures that you name when reading a book
- [ ] Throws a ball overhead
- [ ] Names 1 picture such as a cat, dog, or ball
- [ ] Jumps up
- [ ] Copies things that you do
- [ ] Follows 2-step command
- [ ] When talking, puts 2 words together, like "my book"
- [ ] Turns book pages 1 at a time
- [ ] Plays pretend
- [ ] Plays alongside other children