*code: PD006.b*

# {Office Name} Previsit Questionnaire

# 2.5 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.

**Family Routines**

- ☐ Setting limits on your child's behavior
- ☐ All caregivers using the same rules with your child
- ☐ Doing fun things as a family
- ☐ Day and evening routines
- ☐ Eating together as a family
- ☐ Your child's weight

**Learing to Talk and Communicate**

- ☐ How much TV is too much TV
- ☐ Your child's speech

**Getting Along With Others**

- ☐ Playing well with others
- ☐ How and why to give your child choices

**Getting Ready for Preschool**

- ☐ Is your child ready for preschool
- ☐ Playgroups
- ☐ Toilet training

**Safety**

- ☐ Car safety seats
- ☐ Staying safe near water
- ☐ Playing safe outside
- ☐ Preventing sunburns
- ☐ Preventing fires
- ☐ Staying safe with your pets and others

## 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

**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

**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:**

- [ ] Points to 6 body parts
- [ ] Jumps up and down in place
- [ ] Puts on clothes with help
- [ ] Other people can understand what your child is saying half the time
- [ ] Washes and dries hands without help
- [ ] Plays pretend
- [ ] Plays with other children, like tag
- [ ] When talking, puts 3 or 4 words together
- [ ] Knows correct animal sounds (such as cat meows, dog barks)
- [ ] Brushes teeth with help