24 Month Well Visit Questions **Name, date of birth _____**

Who is your child here with today? _____

Illnesses, injuries, surgeries, hospitalizations since last visit? _____

Medications: _____

Medication allergies: _____

Food allergies: _____

Immunization reactions: _____

Is your child taking vitamins? (Circle what applies) Fluoride, Multi-vitamin, None

SOCIAL:

Changes in child's environment? _____

Who lives with the child in your home? #____Mom, #____ Dad , #____ Brother, # ____ Sister, _____other

Water source: CITY, WELL, BOTTLED

Tobacco exposure: YES, NO

Pets?_____

Daycare: YES, NO

FEEDING:

Milk:, Whole, 2%, 1%, Soy? _____

Ounces of sweetened beverages per day: _____

Eating: (circle) Fruits, Dairy, Vegetable, Meats?

Is your child off of the bottle? YES, NO

Is your child off of the pacifier? YES, NO

ELIMINATION: Any issues urinating or with bowel movements? _____

SLEEP: hours without waking through night _____

BEHAVIOR (circle one) No problems, usually happy, Frequent tantrums, Irritable

DEVELOPMENT:

1. Runs/Jumps: YES, NO
2. Walks up and down stairs: YES, NO
3. Throws overhand: YES, NO
4. Uses a cup: YES, NO
5. Uses a fork/spoon YES, NO
6. Tries to dress him/herself: YES, NO
7. Scribbles with a crayon: YES, NO

8. Stacks 4-6 blocks: YES, NO

9. Knows his/her name: YES, NO

10. Says 30-50 words: YES, NO

11. Says 2 or 3 word sentences: YES, NO

12. Names any body parts: YES, NO

13. Follows a simple command: YES, NO

14. Sorts by shape or color: YES, NO

15. Plays make-believe: YES, NO

16. Enjoys the company of other children: YES, NO

17. Do you think that your child hears well? YES, NO

18. Do you think that your child sees well? YES, NO

19. Do you read to your child? YES, NO

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TB Questions

Does your child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or abnormal chest x-ray?

YES, NO, UNKNOWN

Has your child been in close contact with a person sick with active TB? YES, NO, UNKNOWN

Has your child been exposed to anyone who has been in jail or prison in the past 5 years? YES, NO, UNKNOWN

Was your child born outside of the U.S. or has your child traveled outside the U.S.? YES, NO, UNKNOWN

Does your child have a household member who was born outside the U.S. or who has traveled outside the U.S.? YES, NO, UNKNOWN

Has your child been exposed to any of the following?

HIV infected individuals? YES, NO, UNKNOWN

Homeless persons YES, NO, UNKNOWN

Users of IV and/or other street drugs? YES, NO, UNKNOWN

Residents of nursing homes or group home? YES, NO, UNKNOWN

Migrant workers? YES, NO, UNKNOWN

Does your child have HIV, or risk factors for HIV or any other health problem that could lower the immune system? YES, NO, UNKNOWN

Has your child ever been in jail? YES, NO, UNKNOWN

{International Travel: Exposure to anyone who has traveled outside the United States in last 60 days: YES, NO,