**30 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: _____

Is your child off of the bottle? YES, NO

Is your child off of the pacifier? YES, NO

Does your child eat a good variety of table foods? YES, NO

**ELIMINATION**: Any issues urinating or with bowel movements? _____

**SLEEP**: How many hours does your child sleep without waking through night?_____

Does your child snore? YES, NO

BEHAVIOR (circle one) No problems, Frequent tantrums, Irritable, Disobedient

**DEVELOPMENT**:

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

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

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