



ABC Pediatrics

2 1/2 Year Pre-visit Questionnaire

Patient Name _____

Date _____

Bathes: (Daily) (Every other day)

Feeding Routine

Balanced Diet? _____ Picky eater? _____ Cups of milk daily _____

of stools Daily _____ Fully Potty trained? _____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time _____

Is there any secondhand smoke exposure in your home or car? _____

Developmental Milestones (check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Combines 2 words | <input type="checkbox"/> Dumps cereal/raisins etc. from plate/bowl | <input type="checkbox"/> Follows Simple Directions | <input type="checkbox"/> Greater than 50 word vocabulary |
| <input type="checkbox"/> Hides and finds things | <input type="checkbox"/> Imitates Adults | <input type="checkbox"/> Opens doors | <input type="checkbox"/> Parallel play with other kids |
| <input type="checkbox"/> Runs | <input type="checkbox"/> Kicks a ball | <input type="checkbox"/> Uses fork and spoon | <input type="checkbox"/> Walks up and down steps |
| <input type="checkbox"/> Jumps in place | <input type="checkbox"/> Helps with simple tasks | <input type="checkbox"/> Problem Solves | <input type="checkbox"/> Separates from mom easily |
| <input type="checkbox"/> Throws a ball | <input type="checkbox"/> Listens to stories | <input type="checkbox"/> Problem Solves | <input type="checkbox"/> Uses Pronouns |

Are there any other concerns you would like to discuss?

Lead Risk	Does your child have a sibling or playmate that has had lead poisoning?	YES	NO
	Does your child live in or regularly visit a home built before 1978 that being renovated?	YES	NO
	Does your child live in or regularly visit a house or childcare facility built before 1950?	YES	NO

Weight _____ Temp _____ Height _____ Head Circumference _____