



# ABC Pediatrics

## 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 \_\_\_\_\_ Potty trained? \_\_\_\_\_ # 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"/> Problem Solves         | <input type="checkbox"/> Uses Pronouns                             |  |  |

Are there any other concerns you would like to discuss?

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TB Screen	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO
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 \_\_\_\_\_