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? _____

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)

☐ Combines 2 words	☐ Dumps cereal/raisins etc. from plate/bowl	☐ Follows Simple Directions	☐ Greater than 50 word vocabulary
☐ Hides and finds things	☐ Imitates Adults	☐ Opens doors	☐ Parallel play with other kids
☐ Runs	☐ Kicks a ball	☐ Uses fork and spoon	☐ Walks up and down steps
☐ Problem Solves	☐ Uses Pronouns		

Are there any other concerns you would like to discuss?

_____

_____

_____

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_____