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?_________

Current Dentist:_________________________ Current Daycare:______________________________

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?

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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**

For Office Use Only

Weight______ Temp_________Height_______ Head Circumference________ GoCheck__________

Please Turn Over

M-CHAT

Name: ________________________________**DOB**:_________________**Date**:_________________

INSTRUCTIONS:
Please fill out the following about how your child *usually* is. Please try to answer every question. **If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.**

1. If you point at something across the room, does your child look at it? YES NO
2. Have you ever wondered if your child might be deaf? YES NO
3. Does your child play pretend or make-believe? YES NO
4. Does your child like climbing on things? YES NO
5. Does your child make unusual finger movements near his or her eyes? YES NO
6. Does your child point with one finger to ask for something or to get help? YES NO
7. Does your child point with one finger to show you something interesting? YES NO
8. Is your child interested in other children? YES NO
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? YES NO
10. Does your child respond when you call his or her name? YES NO
11. When you smile at your child, does he or she smile back at you? YES NO
12. Does your child get upset by everyday noises? YES NO
13. Does your child walk? YES NO
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her ? YES NO
15. Does your child try to copy what you do? YES NO
16. If you turn your head to look at something, does your child look around to see what you are looking at? YES NO
17. Does your child try to get you to watch him or her? YES NO
18. Does your child understand when you tell him or her to do something? YES NO
19. If something new happens, does your child look at your face to see how you feel about it? YES NO
20. Does your child like movement activities? YES NO

Pass______ Fail_______