Well Child Questionnaire for Children Less Than Two Years Old

Patient name: _____ Birthdate: _____

Person completing form: _____ Today's date: _____

Please list any changes in the patient's home since the last visit. _____

_____

Please list any changes to patient's family medical history since the last visit. _____

_____

Please list any medical care received outside of our office since the last visit. _____

_____

Please list all of the patient's current medications. _____

_____

Please list any known allergies. _____

Please circle or fill in where indicated.

1) What type of milk does the patient take? Breast Formula Other milk (cow/soy/etc)

Please list formula/specific milk type here: _____

What type of water is used to mix the patient's formula or is given separately to the patient?

Tap Filtered tap Bottled, fluoride free Bottled, fluoride supplemented Well

2) How many breast or bottle/cup feedings a day? _____

3) For bottle/cup feedings, how many ounces does the patient typically take per feed? _____

4) Please list any multivitamin, iron, fluoride or other nutritional supplement the patient is receiving:

_____

5) For patients 4months of age and older, how many spoon feedings/meals a day is the patient receiving? ____

6) Which of the following does the patient receive: cereals/grains fruits/vegetables meats

Yogurt/cheese/other dairy eggs peanut or tree nut spreads fish/shellfish honey

7) Please list any juices and the amount per day the patient receives? _____

8) Has the patient had any hives, facial swelling, immediate vomiting, breathing difficulty or other symptoms that concern you after consuming anything? If so, please describe.

_____

9) How many stools does the patient typically have a day? _____

Does the patient have significant difficulty passing BMs? Yes No

Has the patient repeatedly had blood or mucous in their BMs? Yes No

10) How many hours does the patient typically sleep without awakening at night? _____

How many hours of daytime sleeping does the patient typically have? _____

Does the patient sleep in their own bed? Yes No

Does the patient fall asleep on their own? Yes No

Do you have any concerns regarding the patient's sleep? _____

_____

11) Please circle the patient's abilities. holds head steady rolling crawling

sits unassisted pulls to stand cruises along furniture taking steps

walking independently takes steps backwards runs climbing

12) Please circle the patient's abilities. regards your face smiles laughs

coos jabbers uses "mama/dada", but NOT specifically uses "mama/dada" specifically

uses 1-3 words consistently uses 6-10 words consistently uses >20 words

Combines 2 words together speaks in 3-4 word sentences has full conversations

13) Please list any form of childcare that the patient attends. _____

14) Does the patient take interest in other children? Yes No

15) Does the patient seek comfort from a person when they are hurt/scared? Yes No

16) Did the patient pass their hearing screen as a newborn? Yes No Not known

Do you have any concerns regarding the patient's hearing? Yes No

17) Do you have any concerns regarding the patient's vision? Yes No

18) You will be given a specific screening tool for autism at age appropriate intervals. Please list any specific concerns you have regarding your child's social habits at this time.

_____

_____

19) The patient should have their teeth/gums brushed 2x a day with NON-fluoride tooth paste or water.

The patient needs a "dental home" for regular check ups and emergencies.

Please list any dental concerns you have. _____

20) The patient needs to be restrained in a 5 point style car seat, rear facing until 2 years of age. Please read the height/weight limitations of the patient's current car seat to determine when they should move to another seat. It is recommended that any car seat involved in an accident be replaced. Please list any concerns regarding the patient's car seat. _____

_____