

Two Year Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out **BOTH SIDES**

- | | | | |
|---|-----|----|--------|
| Does your child walk up stairs? | Yes | No | Unsure |
| Can your child jump in place? | Yes | No | Unsure |
| Can your child make a stack of blocks? | Yes | No | Unsure |
| Can your child brush her teeth with your help? | Yes | No | Unsure |
| Does your child use a spoon and cup well? | Yes | No | Unsure |
| Does your child do pretend play using toys? | Yes | No | Unsure |
| Does your child scribble? | Yes | No | Unsure |
| Does your child climb to get objects? | Yes | No | Unsure |
| Does your child respond to two part commands?
("Please get the book and also get your shoes.") | Yes | No | Unsure |
| Does your child use at least 20 words? | Yes | No | Unsure |
| Does your child combine 2 or more words? | Yes | No | Unsure |

How many ounces of milk does your child drink in 24 hours? _____ oz; whole lowfat nonfat

How many ounces of juice does your child drink in 24 hours? _____ oz

Is your child completely weaned from the bottle? Yes No

Does your child eat meat (such as fish, chicken, beef or pork)? Yes No

Do you read to your child regularly? Yes No Unsure

On a typical day, does your child have less than 2 hrs of screen time?
(TV, video, computer, etc) Yes No Unsure

Have you started toilet training? Yes No Unsure

Is your home child-proofed? Yes No Unsure

Do you usually use sunscreen for your child when outdoors? Yes No Unsure

Who provides daytime care for your child? _____

Does your child have access to a home pool? Yes No Unsure

PLEASE TURN OVER

Your Child's Name: _____

Has your child seen a dentist? Yes No Unsure
 Does your tap water contain fluoride? Yes No Unsure
 Is your child on any medications or supplements, including fluoride? If so, please list below:

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950? Yes No Unsure
 Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)? Yes No Unsure
 Does your child have a sibling or playmate who has or did have lead poisoning? Yes No Unsure
 Does your child take any imported home remedies or supplements? Yes No Unsure

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No
 Has a family member had a positive tuberculin skin test? Yes No
 Was your child born in a high-risk country?
 (Countries **other** than the United States, Canada, Australia, New Zealand, or western European countries) Yes No
 Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week?
 (Countries **other** than the United States, Canada, Australia, New Zealand, or western European countries) Yes No

Risk Assessment for abnormal lipid profile (such as high cholesterol):

Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)? Yes No Unsure
 Do either of the child's parents have a cholesterol level of 240 or higher? Yes No Unsure
 Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?



Modified Checklist for Autism in Toddlers (M-CHAT)

Please fill out the following about your child's behavior. 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.

	NO	YES
1. Does your child enjoy being swung or bounced on your knee?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child take an interest in other children?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child like climbing on things, such as up stairs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child ever use his or her index finger to point and ask for something?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child ever use his or her index finger to point and indicate interest in something?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling or dropping them?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child ever bring objects over to you to show you something?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child look you in the eye for more than a second or two?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child ever seem oversensitive to noise (e.g., plugging ears)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your child smile in response to your face or your smile?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child imitate you? (You make a face; will your child imitate it?)	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your child respond to his or her name when you call?	<input type="checkbox"/>	<input type="checkbox"/>
15. If you point at a toy across the room, does your child look at it?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your child walk?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does your child look at things you are looking at?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does your child make unusual finger movements near his or her face?	<input type="checkbox"/>	<input type="checkbox"/>
19. Does your child try to attract your attention to his or her own activity?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever wondered if your child is deaf?	<input type="checkbox"/>	<input type="checkbox"/>
21. Does your child understand what people say?	<input type="checkbox"/>	<input type="checkbox"/>
22. Does your child sometimes stare at nothing or wander with no purpose?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	<input type="checkbox"/>	<input type="checkbox"/>