Pediatric Health Maintenance: 2 Years

Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health ☐ I'd like to discuss		
☐ Yes	☐ No	Is your child in daycare or the care of a babysitter?
☐ Yes	☐ No	Do you have concerns about your child's vision or hearing?
☐ Yes	☐ No	Do your child's eyes ever appear to cross or drift apart?
☐ Yes	☐ No	Does your child snore most nights?
☐ Yes	☐ No	Does your child use bottles or pacifiers?

Diet, Sleep, & Elimination ☐ I'd like to discuss		
What type of milk does your child drink? ☐ Whole ☐ 1-2% ☐ Skim ☐ Other		
How much milk does your child drink each day?		
☐ Yes	☐ No	Are you concerned about your child's weight or eating habits?
☐ Yes	☐ No	Does your child eat a good variety of foods (meat, vegetables, grains, and fruit)?
☐ Yes	☐ No	Do you eat meals as a family?
☐ Yes	☐ No	Do you brush your child's teeth twice a day?
☐ Yes	☐ No	Does your child sleep through the night?
☐ Yes	☐ No	Do you think your child's bowel movements are normal?

Development ☐ I'd like to discuss		
☐ Yes	☐ No	Does your child say at least 50 words?
☐ Yes	☐ No	Does your child say 2-word sentences?
☐ Yes	☐ No	Can your child use a spoon well?
☐ Yes	☐ No	Can your child take off his or her clothes and unzip zippers?
☐ Yes	☐ No	Can your child kick a ball and throw one overhand?
☐ Yes	☐ No	Does your child climb up and down stairs on one leg at a time?

Safety ☐ I'd like to discuss		
☐ Yes	☐ No	Does your child ride in a car seat, in the back seat?
☐ Yes	☐ No	Are all medicines and household products in a locked cabinet?
☐ Yes	☐ No	Do you give your child raw vegetables, hard candy, gum, nuts, or popcorn?
☐ Yes	☐ No	Do you leave your child alone in the bathtub?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 2 Years form.

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME & ID #

www.m-chat.org

First & Last Name _____ Preferred Name _____

Date of birth _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please select **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes ☐	No ☐
2. Have you ever wondered if your child might be deaf?	Yes ☐	No ☐
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes ☐	No ☐
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes ☐	No ☐
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes ☐	No ☐
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes ☐	No ☐
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes ☐	No ☐
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	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? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes ☐	No ☐
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing 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? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	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? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when 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? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes ☐	No ☐
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes ☐	No ☐
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes ☐	No ☐
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes ☐	No ☐

Lead Screening Questionnaire

Virginia Mason

First & Last Name: _____

Preferred Name: _____

Date of Birth: _____

Please check any boxes if you answer YES

- ☐ Do you live in or regularly visit any house built before 1950?
- ☐ Do you live in or regularly visit any house built before 1978 with recent or ongoing renovations?
- ☐ Does your family qualify as low income? (less than 130% of the poverty level)
- ☐ Does your child have a sibling or frequent playmate with elevated blood lead level?
- ☐ Is your child a recent immigrant, refugee, foreign adoptee, or in foster care?
- ☐ Do any parent or caregivers work professionally or recreationally with lead?

  Remodeling and demolition; painting; works in or visits gun ranges; mining; battery recycling; makes lead fishing weights or shotgun pellets; hobbies involving stained glass, pottery, soldering, or welding.

- ☐ Does your family use any traditional, folk, or ethnic remedies or cosmetics (such as Greta, Azarcon, Ghasard, Ba-baw-san, Sindoor or Kohl)?
- ☐ **My child has none of the above**