



Office Use Only

- VFC: [] MDD/DKC
- [] Native
- [] NO Insurance
- [] Not Eligible

INSURANCE Notes

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WT: _____ lb _____ kg
 Height: _____
 OFC: _____

2 Year Well Child Questionnaire

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

Child's Name: _____ **Birth Date:** _____

- Do you have any concerns about your child today? _____
- Is your child on any medicine? Yes / No. Which ones/dose? _____
- Any allergies to medicines, foods, latex, etc.? Yes / No. Which ones? _____
- Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? _____
- Has your child had any surgeries? Yes / No. If yes, describe: _____
- Has your child been hospitalized overnight? Yes / No. Is yes, why: _____

Health

Is your child exhibiting any of the following symptoms?

- | | | | |
|------------------------|-----------------------------------|------------|----------------------------------|
| Ear Pain / Ear Pulling | Yes / No. If yes, how long? _____ | Fever | Yes / No. If yes, how long _____ |
| Headache | Yes / No. If yes, how long? _____ | Neck Pain | Yes / No. If yes, how long _____ |
| Chest Pain | Yes / No. If yes, how long? _____ | Cough | Yes / No. If yes, how long _____ |
| Decreased Appetite | Yes / No. If yes, how long? _____ | Vomiting | Yes / No. If yes, how long _____ |
| Abdominal Pain | Yes / No. If yes, how long? _____ | Diarrhea | Yes / No. If yes, how long _____ |
| Urinary Symptoms | Yes / No. If yes, how long? _____ | Rash | Yes / No. If yes, how long _____ |
| Sleep Problems | Yes / No. If yes, how long? _____ | Joint Pain | Yes / No. If yes, how long _____ |

Nutrition

- Whole milk? Yes / No. Ounces per day: _____
- If 8 oz milk, 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy does your child consume each day? _____
- Is your child still breastfeeding? Yes / No. How many times per day? _____
- Circle your child's water supply source: City Bottled Well. Is your child on a cup AND off the bottle? Yes / No.
- Can your child use an open cup (not a sippy cup)? Yes / No. Does your child use a pacifier? Yes / No.
- How many ounces of juice, soda and other sugar-sweetened beverages does your child consume each day? _____
- Does your child eat a reasonable amount and variety of table foods? Yes / No.
- Is your child on vitamins? Yes / No. Which brand? _____

Social

- Any changes in your child's environment? (new home, pets, daycare, etc.) _____
- Who lives in the household with you? _____
- Who is the primary caretaker? _____ Is Mom working? Yes / No. Full time / Part Time
- Does anyone in the family smoke? Yes / No. If yes, who? _____
- Is your child in daycare? Yes / No. If yes, where? _____
- Any pets? Yes / No. If yes, which kind? _____
- Any food allergies in your family? Yes / No. If yes, who and to what? _____
- Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____
- Are there firearms in your home? Yes / No.

Sleep and Elimination

- How many hours straight does your child sleep at night? _____
- Does your child nap daily? Yes / No. If yes, how often and how long? _____
- Does your child have any problems with urinating? Yes / No.
- Any problems with stooling? Yes / No. Is your child potty trained? Yes / No.

This form completed by: _____ Relationship to Child: _____