



# Health Maintenance Questionnaire

# 2 YEARS

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION		PHYSICIAN'S COMMENTS
<b>H I S T O R Y</b>	Describe any recent injuries or illnesses: _____	<input type="checkbox"/> Increasing independence  <input type="checkbox"/> Discussed risks of 2 <sup>nd</sup> hand smoke.  <input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Brush teeth.  <b>Shaded items are new for the 2 yr check-up.</b> <b>FEEDING RECOMMENDATIONS</b> <input type="checkbox"/> May switch to 2% milk. <input type="checkbox"/> Limit juices. <input type="checkbox"/> Regular family meals. <input type="checkbox"/> Avoid meal time battles / Variable appetite at this age. <input type="checkbox"/> Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins, gum.  <input type="checkbox"/> Breast feeding may be weaned gently and gradually when Mom and baby are ready.  <b>TOILETING RECOMMENDATIONS</b> <input type="checkbox"/> Consider starting toilet training if ready. (longer dry periods, dislikes soiled diaper, words) Reward success and ignore failures.
	List medications taken routinely: <input type="checkbox"/> none	
	Note any new stresses in the family: _____	
	Is your child in day care? <input type="checkbox"/> No <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other: How many kids? Are there any smokers in your child's home or daycare? <input checked="" type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room Does your child drink water that is fluoridated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
<b>N U T R I T I O N</b>	How many ounces per day of  Whole milk _____ Juice _____ How many servings per day of  Meat _____ Fruit _____ Veggies _____ <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Are snacks scheduled? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child using a spoon and fork? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child off of the bottle? If nursing, how many times per day?	
	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child showing any interest in toilet training? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child pass stools without problems?	

PHYSICAL EXAM		LAB	IMMUNIZATIONS
Ht _____ Wt _____ HC _____ VS: _____	Check if normal: <input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Heart <input type="checkbox"/> Hips <input type="checkbox"/> Eyes/Red reflexes <input type="checkbox"/> Throat <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Extremities <input type="checkbox"/> Ears <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Chest <input type="checkbox"/> Genitalia <input type="checkbox"/> Neurologic	<input type="checkbox"/> Hgb <input type="checkbox"/> Lead <input type="checkbox"/> PPD placed Other: _____	<input checked="" type="checkbox"/> Given at Health Department Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?  <input type="checkbox"/> DTaP <input type="checkbox"/> HepB <input type="checkbox"/> IPV <input type="checkbox"/> Hib <input type="checkbox"/> Comvax <input type="checkbox"/> MMR <input type="checkbox"/> Prevnar <input type="checkbox"/> Varivax Other: _____
NOTE EXAM ABNORMALITIES HERE			

### ASSESSMENT

- NORMAL GROWTH and DEVELOPMENT. More information on other side.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### PLAN

- Follow up at **3 years** for Health Review.  Anticipatory handouts given.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Do you have concerns about your child's vision or hearing?  Yes  No

**2 years**

DEVELOPMENTAL ASSESSMENT	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's development?	
<b>M O T O R</b>	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Do you encourage physical activities? <input checked="" type="checkbox"/> <input type="checkbox"/> Can your child climb up and down stairs 1 step at a time? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he jump? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he kick a ball? <input checked="" type="checkbox"/> <input type="checkbox"/> Can your child throw a ball overhand? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he open doors? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he stack 5 blocks? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child help with dressing? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he copy a straight or circular line?
	<b>L A N G U A G E</b> <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child say 20 words with meaning? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he say 2 word phrases? <input checked="" type="checkbox"/> <input type="checkbox"/> Are pronouns used (I, me, you), but sometimes incorrectly? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation? (Unclear speech is normal between 2-4 years old.) <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child follow 2 part commands? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he enjoy singing, nursery rhymes and counting? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you read/look at picture books with your child everyday? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit TV to less than 2 hours per day?
	<b>S O C I A L</b> <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child refer to self by name? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate adults? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you ask your child to help pick up toys? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child problem solve? (moves chair to counter) <input checked="" type="checkbox"/> <input type="checkbox"/> Is sharing difficult for him/her? (typical at this age) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you arrange play time with other children? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you provide musical and push toys? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child give hugs and kisses? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child curious about body parts? (normal)

BEHAVIOR RECOMMENDATIONS	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's behavior?	
If these were reviewed previously, check this box. <input type="checkbox"/> You may skip to the "Sleep" box.	
<b>M O T O R</b>	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child becoming more independent? (normal) <input checked="" type="checkbox"/> <input type="checkbox"/> Is your discipline consistent? (very important) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you show affection regularly? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-in frequently? (praising good behavior) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-out? (removing attention when doing unacceptable behavior) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you set limits and choose your battles wisely? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you try to give choices whenever it is reasonable? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you occasionally say "no"? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you try to ignore tantrums? (very typical)
	<b>S L E E P</b> <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child sleep well? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you maintain a bedtime routine? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child take naps OK? (variable number per day) <input checked="" type="checkbox"/> <input type="checkbox"/> Are you considering the transition into a big bed? <input checked="" type="checkbox"/> <input type="checkbox"/> Are you OK with your child's use of self-comforting behaviors? <input type="checkbox"/> thumb sucking <input type="checkbox"/> pacifier <input type="checkbox"/> favorite object? <input type="checkbox"/> None Where does your child usually sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 2 year visit.	
If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Is the car seat in the back seat? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input checked="" type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you have window guards? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your doors locked? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor play near streets and driveways?	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child always closely supervised in the house and car? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child? <input checked="" type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input checked="" type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?

TUBERCULOSIS (TB) RISK		
If you reviewed these TB risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/> Skip to the "Lead Risk" box.	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test? <input type="checkbox"/> <input checked="" type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America? <input type="checkbox"/> <input checked="" type="checkbox"/> Is anyone living in your house infected with HIV? <input type="checkbox"/> <input checked="" type="checkbox"/> Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers. <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?	TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

LEAD RISK		
If you reviewed these Lead risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/>	<b>Y N</b> <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child live in or visit a house built before 1978? <input checked="" type="checkbox"/> <input type="checkbox"/> Is there a sibling or playmate with lead poisoning? <input type="checkbox"/> <input checked="" type="checkbox"/> Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways? <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead? <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**