



WELL CHILD CHECK UP: 1 – 2 Years

Patient's Name _____ D.O.B. _____ Age _____ Date _____

Interval History:

Has your child been ill since the last check-up? Yes No If yes, please describe: (Hospitalization, surgery, illness) _____

What medications, supplements, or vitamins is your child taking, if any? _____

Does your child have any allergies? Yes No What kind? _____

Has your child had a reaction to shots before? Yes No If yes, describe: _____

What concerns or questions do you have about your child, if any? _____

Nutrition:

How is your child's appetite? Good Average Poor Cups of juice per day _____

Milk: Whole milk 2% or 1% Skim Soy Cups of milk per day _____

Other (cereal, water, food, etc.)? _____

Are you still breastfeeding? If so, _____ minutes, every _____ hours, _____ times a day.

How many teeth does your child have? _____ Do you brush his/her teeth? Yes No

Does your child eat paint or dirt? Yes No

Any problems with urine output or bowel movements? _____

Development / Language / Motor:

How many words does your child say? _____ How many phrases? (I want that, give it to me,...) _____

Does your child... Stand alone Walk with help Walk alone Feed him/her self

Check box only if YES Dress him/herself Run Walk up / down stairs Use a cup

Use a spoon Throw a ball overhand

Do you have any concerns about your child's development? If yes, please describe: _____

Safety / Home:

Do you use a car seat? Yes No What position is it in? Rear-facing Forward-facing

Do you have a working smoke detector? Yes No

Is your child exposed to smoke? Yes No Is there a gun in your home? Yes No

Please describe your childcare arrangements: _____

Who lives in your household? _____

Any pets? If yes, what kind? _____

Has anyone physically abused or threatened you or your children? Yes No

TB Screening Questions: Has your child been around anyone ... who has HIV or uses IV drugs? Yes No

... who lives in a group or nursing home? Yes No ... who has traveled to another country? Yes No

... who has been homeless or incarcerated (in jail)? Yes No

Behavior:

What do you do when your child misbehaves? _____

Any behavior problems? Yes No If yes, describe: _____

How many hours does your child sleep at night? _____ During the day? _____

Do you want to discuss (check if YES): Toilet training Eating problems Sleep problems

→ Please indicate relationship of person completing form: _____

Signature: _____

Date: _____