PEDIATRIC HEALTH MAINTENANCE – 2 ½ Years
Parent Questionnaire

General

Do you have any concerns or worries about your child or your child's development? ______ No ______ Yes

If yes, please specify: ____________________

Is your child in daycare or the care of a babysitter? ______ No ______ Yes

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

Do your child's eyes ever appear to cross or drift apart? ______ No ______ Yes

Does your child use bottles or pacifiers? ______ No ______ Yes

Has your child seen a dentist? ______ Yes ______ No

Diet, Sleeping, and Elimination

What type of milk does your child drink? ____________________

How much milk does your child drink each day? ____________________

Are you concerned about your child's weight or eating habits? ______ No ______ Yes

Does your child eat a good variety of foods (meat/protein, vegetables, grains, 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? ______ Yes ______ No

Is your child toilet trained for daytime? ______ Yes ______ No

Development

Does your child say at least 50 words and make 2-word sentences? ______ Yes ______ No

Does your child follow 2-step instructions like, "put toy down and close the door" ______ Yes ______ No

Does your child use hands to twist things, like turning doorknobs/unscrewing lids? ______ Yes ______ No

Can your child take clothes off by themself, like loose pants or an open jacket? ______ Yes ______ No

Can your child kick a ball and throw one overhand? ______ Yes ______ No

Uses things to pretend, like feeding a block to a doll as if it were food? ______ Yes ______ No

Can your child jump off the ground with both feet? ______ Yes ______ No

Safety

Are all medicines and household products in a locked cabinet? ______ Yes ______ No

Do you give your child hard raw vegetables, hard candy, gum, nuts, or popcorn? ______ No ______ Yes

Do you leave your child alone in the bathtub? ______ No ______ Yes

Does your child ride in car seat in the back seat? ______ Yes ______ No

Are there any smokers in your home? ______ No ______ Yes

Do you have a firearm in your home? ______ No ______ Yes

If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them?

Are you afraid of your partner or anyone close to you? ______ No ______ Yes

Do you feel overly stressed or unsupported? ______ No ______ Yes

____________________ Completed by (name and relationship to patient)

____________________ Date (month/day/year)

PATIENT NAME

VIRGINIA MASON FRANCISCAN HEALTH
Pediatric Health Maintenance – 2 ½ Years
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