PEDIATRIC HEALTH MAINTENANCE – 2 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

Diet, Sleeping, and Elimination

What type of milk does your child drink? □ Whole □ 1-2% □ Skim □ Soy

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

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 Years

VMMC Form 99461 (08-24)

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