Name: _____ Date of birth: _____

Health Status Questionnaire – 2 1/2 years

Child lives with: mother father both parents other:_____

Childcare: daycare babysitter stays at home other:_____

Eating habits:
__ meals __ snacks __ grazes __ picky __adequate fruits/veggies
__ mostly meats/starches __ lots of juice(should be less than 6oz per day)
Milk/dairy products: ___ times per day

Toilet habits: normal day trained not trained
Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Car seat use:	Y	N	Smoke detectors:	Y	N
Sunscreen:	Y	N	Fire extinguishers:	Y	N
Insect protection:	Y	N	Firearms/guns in house:	Y	N
Home child proofed:	Y	N	Locked away:	Y	N
Dental visit:	Y	N	Passive smoke exposure:	Y	N

Vision screen:

Does your child hold objects close when trying to focus or squint?	Y	N
Do your child's eyes appear unusual, seem to cross or be lazy?	Y	N
Do your child's eyelids droop or does one eyelid tend to close?	Y	N

Development concerns: none speech motor social cognitive vision hearing

Does your child:

Play pretend?	Y	N
Play with other children?	Y	N
Speak in 3-4 word phrases?	Y	N
Point to 6 body parts?	Y	N
Knows correct animal sounds(cat meows, dog barks)?	Y	N
Jump up and down in place?	Y	N
Puts on clothes with help?	Y	N
Brushes teeth with help?	Y	N

Do you have any concerns about your child?

_____