2 1/2 Year Parent Questionnaire

Scan this code for age specific health information

Date:

Do you have any concerns about your child's:

No | Yes eating? No | Yes sleeping? No | Yes vision?
No | Yes hearing? No | Yes screen time? No | Yes potty training?

Do you have any concerns about:

No | Yes recent changes or stress (job change, move, divorce, illness)?
No | Yes any injury since the last visit? ☐ No injuries
No | Yes use of alcohol or drugs by anyone caring for your child?
No | Yes conflict or violence that your child is exposed to?
No | Yes rules or discipline for your child?

Does your child:

No | Yes eat fast food more than once a week?
No | Yes get less than 1 hour of active play per day?

Do you:

Yes | No take your child to the dentist each year?
Yes | No have your child brush their teeth daily?
Yes | No always use a car seat? (5-point harness, in the backseat)
Yes | No have working smoke alarms and carbon monoxide detectors in your home?
Yes | No know CPR & the rescue maneuver for choking?
Yes | No put sunscreen on your child?
Yes | No avoid foods that can cause your child to choke? (hot dogs, peanuts, popcorn, raw carrots, hard candy)
Yes | No If you own a gun, is it locked, with bullets stored separately? ☐ No gun in home
Yes | No have internet access to view health information from our website?

Family Medical History

No | Yes Have there been any changes to your family medical history?
No | Yes Is there a family history of early heart disease? (under age 65 for women, age 55 for men)
No | Yes Does your child have a parent with total cholesterol over 240 mg/dL?

Social Determinants of Health

Within the past 12 months, you worried that your food would run out before you got money to buy more. ☐ Often true ☐ Sometimes true ☐ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. ☐ Often true ☐ Sometimes true ☐ Never true

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? *(check all that apply)*

☐ Yes, it has kept me from medical appointments or getting medication
☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
☐ No

Would you like information regarding these concerns? *(check all that apply)*

☐ Yes, have someone contact me ☐ Yes, I would like written information ☐ No

Please write down any questions or concerns that you would like to talk about today:

Name: _____

Birthdate: _____

_____Provider initials