Woodinville Pediatrics 2 Year Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Family
Parents working outside home ____mother ____father
Child Care ____yes ____no Type_____
Changes since last visit _____

Diet
Nutrition: ___Breast ___Bottle ___Cup
Milk _____ Ounces per day _____
Source of water _____ Vitamins/Fluoride_____
Juice Amount_____
Diet Concerns ___yes ___no
Diet comments _____

Bowel/Bladder
Stool Concerns ____yes ____no
Stool Consistency ____hard ____soft
Urination Concerns ____yes ____no

Sleep
Back sleeping ____yes ____no
Location ____co-sleep ____crib ____co-sleep & crib
Duration ____ < 3 hrs ____ 3-6 hrs ____ > 6 hrs

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Physical Activity Play time (60m/d) ___yes ___no
Screen time (<2hr/d) ___yes ___no

Development
Social Emotional: ___Copies things that you do
___Plays Pretend
___Plays alongside other children
Communication: ___When talking puts 2 words together (my book)
Cognitive: ___Names 1 picture (eg cat dog)
___Follows 2-step commands
Physical : ___Stacks small blocks (5-6)
___Kicks a ball
___Walks up and down stairs
___Throws a ball overhand
___Jumps up
___Turns book pages 1 at a time

Additional comments: _____

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