Reedsburg AREA MEDICAL CENTER Physicians Group

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Patient Questionnaire – 24 Month Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic caregiver stress at home
Nutrition	
Types of intake (please circle)	Breast Milk Eggs Fruits Junk food Non-nutritional Cereals Fish Juices Meats Vegetables Cow's Milk
Junk Food (please circle)	Candy Desserts Fast Food Soda Sugary Drinks Chips
Dental	
Has dental home (please circle)	Yes No
Elimination	
Elimination Problems (please circle)	Diarrhea Urinary Symptoms Constipation Gas

Please see reverse side

Behavior	
Behavioral Issues (please circle)	Biting Stubbornness Waking up at night Hitting Throwing tantrums
Disciplinary Methods (please circle)	Consistency among caregivers Scolding Taking away privileges Ignoring tantrums Spanking Time outs Praising good behavior
Sleep	
Sleep Location (please circle)	Crib Own Bed Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretaker's arms while feeding On own In caretaker's arms **Average sleep duration in hours: _____**
Sleep Problems (please circle)	Yes No

Safety/Environment			
Home is child-proofed (please circle)	Yes No Partially		
Smoking in home (please circle)	Yes No		
Working smoke alarms (please circle)	Yes No Don't know		
Working CO (carbon monoxide) alarms (please circle)	Yes No Don't know		
Car seat (please circle)	Yes No		
Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes No	**Risk factors for apnea** (please circle)	Yes No
Risk factors for anemia (please circle)	Yes No		

Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider

Days per week at daycare: _____

Hours per day at daycare: _____

Sibling interactions (please circle)	Good Fair Poor

Growth and Development

Do you or your family/childcare provider have concerns about your child's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your child:

Have behavior or emotional development that makes you concerned? (please circle)

Yes No

Concern you because of lack of speech or social skills? (please circle)

Yes No

Look in your eyes for more than a second or two? (please circle)

Yes No

Show interest in other children? (please circle)

Yes No

Play alongside other children? (please circle)

Yes No

Pretend play (example: talk in phone)? (please circle)

Yes No

Uses 50 words or more frequently? (please circle)

Yes No

Please see reverse side

Growth and Development Cont.

Does your child:

Put 2 words together, such as "more juice" (not just repeating)? (please circle)

Yes No

Know some body parts? (please circle)

Yes No

Point to pictures when you say a word (example: cat, bird, dog)? (please circle)

Yes No

Stack 4 blocks? (please circle)

Yes No

Walk up the stairs, run, kick a ball? (please circle)

Yes No