MUNDELEIN PEDIATRICS

2 Year Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
   (____) hours from naps during the day
2. Good eating habits: Yes/No Concerns: _____
   Milk: (____) ounces of milk daily
   Fruit juice: (____) ounces of fruit juice daily
3. Urinating well: Yes/No Concerns: _____
4. Potty training in process Yes/No Concerns: _____
5. Normal bowel movements: Yes/No Concerns: _____
6. Takes vitamins: Yes/No Product name: _____
7. Emergency room visits: Yes/No
8. Illness since last visit: _____

Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Firearms at home Yes/No If yes, are safety precautions taken: Yes/No
4. Television/video game time: Yes/No Hours per day: _____
5. Rides in a car seat in the back seat: Yes/No
6. Daycare: None/Relative/Center/Babysitter
7. Primary care taker: Mom/Dad/Grandparents
8. Household composition:
   Adult(Names/Ages): _____

   Children(Names/Ages): _____

9. New health problems in parents or siblings: _____
10. Past vaccine reactions: Yes/No
11. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

_____

_____

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