

MUNDELEIN PEDIATRICS

2 1/2 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 since last well visit: Yes/No
- 8. Illness since last visit: _____

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

- 1. Smoker in the house/car Yes/No
- 2. Someone smokes outside: Yes/No/ NA Mom/Dad/Sibling/Relative/Babysitter
- 3. Guns/Weapons at home Yes/No If yes, are safety precautions taken: Yes/No
- 4. Screen time/TV/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. Dental Visits Yes/No

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

