



Well Child Health Screen: 24-30 Months

Name: _____ Birthdate: _____ Visit Date: _____

General Health Updates

Who is completing this form?	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to the patient's health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Any concerns about development, learning or behavior?	
Who lives with the patient?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

Development

The following section is used to make sure they are developing normally. Each set of milestones is generally achievable by 75% of children of the same age. If you have questions/concerns, please talk to your provider.

If they are nearest 24 months , check the items they can do most of the time:	<input type="checkbox"/> Looks at your face to see how to react in a new situation
	<input type="checkbox"/> Says at least two words together, like "more milk"
	<input type="checkbox"/> Tries to use switches, knobs, or buttons on a toy
	<input type="checkbox"/> Kicks a ball
	<input type="checkbox"/> Runs
	<input type="checkbox"/> Walks (not climbs) up a few stairs with or without help
	<input type="checkbox"/> Eats with a spoon

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Do you have concerns about their hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any concerns about low iron levels or anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a parent with elevated blood cholesterol level (≥ 240 mg/dL) or who is taking cholesterol medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Family Life

- Are there barriers that prevent you from spending time each day interacting with them? Yes No
- Does anyone in the home/family have problems with drugs or alcohol? Yes No Decline
- Do you have questions or concerns about toilet training? Yes No

Nutrition

- Do you have concerns or questions about what or how they are eating? Yes No
- Do you eat together as a family? Always Sometimes Never
- Do they drink juice? Yes No

Oral Health

- Does anyone in the house have current dental decay/cavities? Yes No Unknown
- Do they take extra fluoride OR drink water that contains fluoride? Yes No Unknown
- Do you brush their teeth twice a day? Yes No
- Are you interested in having fluoride varnish applied during this visit? Yes No Maybe
- Have they been to a dentist in the last 6 months? Yes No

Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

- Do you have any concerns about the amount or quality of their sleep? Yes No

Activity & Screen Time

- Does the patient spend more than two hours per day in front of a screen (TV, phone, video games, etc.) ? Yes No

Safety

- Do you have any questions about what to do when they outgrow their current car safety seat? Yes No
- Do you use sunscreen regularly? Yes No
- Do you have questions about how to keep them safe around water? Yes No
- Do they wear a helmet every time they ride a bike, scooter, skateboard, ski/snowboard? Yes No
- Do you have any questions about how to demonstrate safe behavior around pets and animals? Yes No