2 Yrs Questionnaire

Name of Patient ______________________ DOB___________

1. Feeding History
   a. ☐ Whole milk ☐2% milk ☐1% milk ☐Other_______________
      How much? ____oz every ___hours.
   b. ☐ Bottle ☐Sippy cup ☐Both
   c. Juice: ☐ Diluted ☐ Undiluted How much? ____oz per day.
   d. Solid Food: (please circle) Cereal/Grains, Vegetables, Fruit, Meat,
      Other _____________
2. Stools ☐Normal ☐Lose ☐Hard
3. Has your child been in contact with anybody who has active Tuberculosis ☐Y ☐N
4. Has your child seen a dentist? ☐Y ☐N
   Dentist's Name:_________________ Last Appointment: _______

<u>Development:</u>

1. Vocabulary includes at least 50 words ☐Y ☐N
2. Two word sentences ☐Y ☐N
3. Runs well ☐Y ☐N
4. Throws ball overhand ☐Y ☐N
5. Walks up and down stairs alone (both feet on each step) ☐Y ☐N
6. Stacks tower of 6 ☐Y ☐N
7. Draws horizontal line ☐Y ☐N

Other Comments/ Concerns ____

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