

**PEDIATRIC HEALTH
ASSESSMENT HEALTH
2 TO 3 YEARS**

CHILD'S NAME: _____ DATE: _____ AGE: _____

ALLERGIES (MEDICINES, FOOD, ETC): _____

ALL MEDICATIONS: _____

CURRENT PAST MEDICAL PROBLEMS: _____

PRESENT CONCERNS/PROBLEMS: _____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

DAILY LIVING: (FILLED OUT BY PARENT OR GUARDIAN)

DIET: circle type MILK – WHOLE, 2%, 1%, SKIM (HOW MANY SERVINGS/DAY) _____
 DAIRY OTHER THAN MILK-CHEESE, YOGURT(SERVINGS/DAY) _____
 MEALS (SERVINGS/DAY) CEREAL/BREAD/GRAIN _____ FRUIT _____ VEGS _____ MEAT/PROTEIN _____
 JUICES (CUPS/DAY) _____ SNACKS(HOW MANY/WHAT KIND?) _____
 WATER (CUPS/DAY) _____ CIRCLE: CITY/WELL WHAT OTHER DRINKS (CUPS/DAY) _____
 HOW OFTEN DOES CHILD EAT OUT? _____ (TIMES/WEEK)

- Circle which ones VITAMINS/FLUORIDE/IRON..... NO YES
- ANY ACCESS TO WEAPONS?..... NO YES
- ANY SIBLING RIVALRY OR JEALOUSY?..... NO YES
- ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly..... NO YES
- DO PARENTS OR CAREGIVERS EVER SMOKE?..... NO YES
- ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)? NO YES
- ANY RELATIVES WITH HEART DISEASE OR HIGH CHOLESTEROL BEFORE AGE 55? NO YES
- IS CAR SEAT USED ALL THE TIME?..... NO YES
- HAVE SMOKE ALARMS?..... NO YES
- HOUSE BUILT BEFORE 1980, OR LOCATED NEAR LEAD-RELATED INDUSTRIES?..... NO YES
- HOUSEHOLD MEMBER/CLOSE CONTACT WITH HIGH LEAD WORK/HOBBY EXPOSURE?..... NO YES
- OTHER LEAD EXPOSURE (I.E.: EATS NON-FOOD ITEMS / PICA; USE ANTIQUE DISHES, ETC; USE PRODUCTS FROM OTHER COUNTRIES SUCH AS HEALTH REMEDIES, ETC.)..... NO YES

TOILET TRAINED (ONLY OCCASIONAL ACCIDENTS?) _____ HARD STOOLS OR CONSTIPATION? _____

DESCRIBE MOST COMMON ACTIVITY? Circle which one quiet inactive /plays outside active /tv video games

DESCRIBE PERSONALITY : _____ ANY BEHAVIOR PROBLEMS? _____

DESCRIBE SLEEP HABITS (HOURS/24 HOURS): _____ SLEEPS IN OWN BED? Y/N _____

DESCRIBE WORK/DAY CARE SITUATION: _____

WHO LIVES AT HOME? _____

LAST DENTAL EXAM? _____

DEVELOPMENT: (FILLED OUT FOR THE APPROPRIATE AGE BY PARENT OR GUARDIAN)

	2 YEARS OLD	NO	YES	3YEARS OLD	NO	YES
ANY CONCERN ABOUT VISION OR HEARING?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANY CONCERN ABOUT VISION OR HEARING?.....	<input type="checkbox"/>	<input type="checkbox"/>
ASK FOR FOOD, DRINK, OR TOYS?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALTERNATES FEET WHEN GOING UP STAIRS?.....	<input type="checkbox"/>	<input type="checkbox"/>
GETS ALONG EASILY WITH OTHER CHILDREN?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASKS UNDERSTANDABLE QUESTIONS?.....	<input type="checkbox"/>	<input type="checkbox"/>
GIVES YOU AN OBJECT WHEN ASKED?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEEDS SELF WITH LITTLE SPILLING?.....	<input type="checkbox"/>	<input type="checkbox"/>
HANDLES CUP WELL?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAS FEW TEMPER TANTRUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
HELPS WITH SIMPLE TASKS?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HUGS YOU OR SHOWS AFFECTION?.....	<input type="checkbox"/>	<input type="checkbox"/>
PUTS OBJECT WHERE YOU WANT.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KNOWS THE SEX OF A PARENT?.....	<input type="checkbox"/>	<input type="checkbox"/>
SAYS 20 OR MORE WORDS?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RIDES TRICYCLE USING PEDALS?.....	<input type="checkbox"/>	<input type="checkbox"/>
USES 2 WORD COMBINATIONS?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SAYS HIS/HER OWN NAME?.....	<input type="checkbox"/>	<input type="checkbox"/>
SCRIBBLES EASILY?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SAYS MORE THAN 30 WORDS?.....	<input type="checkbox"/>	<input type="checkbox"/>
SEATS SELF IN SMALL CHAIR?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SPEAKS IN FULL SENTENCES?.....	<input type="checkbox"/>	<input type="checkbox"/>
TRIES TO FEED SELF?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SPEECH IS EASILY UNDERSTOOD BY STRANGERS?..	<input type="checkbox"/>	<input type="checkbox"/>
WALKS/RUNS WELL?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	USUALLY COMES IF CALLED?.....	<input type="checkbox"/>	<input type="checkbox"/>