Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

2 Year Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about any of the following for your child? .... Y N
   Vision Hearing Sleeping Eating
2. Does your child get at least 5 servings of fruits/vegetables most days? .... Y N
3. Does your child get less than 2 hours of TV, movies or computer time per day? .... Y N
4. Does your child get at least 1 hour of active play each day?... Y N
5. Does your child drink sweetened drinks like pop or juice? .... Y N
6. Does your child regularly eat breakfast? .... Y N
7. How many times in a week does your child eat fast food? ____________
8. Have you begun potty training? .... Y N
9. Do you and your partner agree on setting rules and discipline? .... Y N
10. Has your child had any injuries since last visit? .... Y N

SAFETY

11. Do you always use a car seat positioned in the back seat? .... Y N
12. Do you avoid foods that can cause your child to choke? .... Y N
    (hot dogs, peanuts, popcorn, raw carrots, hard candy)
13. Do you have the poison control number (1-800-222-1222) handy? .... Y N
14. Does your child spend time with anyone that smokes? .... Y N
15. Is there a gun in your home? .... Y N
    If yes is it locked?.. Y N
16. Do you put sunscreen on your child?.. Y N
17. Do you have smoke alarms and carbon monoxide detectors in your home? .... Y N
18. Do you have any concerns regarding the use of alcohol or drugs by anyone caring for your child? .... Y N
19. Do you have any concerns regarding conflict or violence that your child might be exposed to? .... Y N

SOCIAL

20. Are there any new stresses or recent changes impacting your family (job changes, move, divorce, illness)? .... Y N

FAMILY MEDICAL HISTORY

21. In the past year has anyone in your child's extended family been diagnosed with a chronic illness (such as heart disease or diabetes)? .... Y N

Parent / Guardian Signature and Date	Provider Signature and Date

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LEAD RISK

22. Do you have reason to believe that your child may have blood lead poisoning? .... Y N
23. Has your child moved to Ohio from a foreign country or from a major metropolitan area within the last 12 months? .... Y N
24. Does your child live within the city limits of Columbus? (not the suburbs) .... Y N
25. Do you receive Medical Assistance (MA) which includes: Prepaid Medical Assistance Program (PMAP)? .... Y N
26. Will your child be attending Headstart? .... Y N
27. During the past six months, has your child lived in or regularly visited a home, childcare, or other building built before 1978 with recent or ongoing repair, remodeling or damage (such as water damage or chipped paint)? .... Y N
28. During the past six months, has your child lived in or regularly visited a home, childcare or other building built before 1950? .... Y N
29. Has your child's brother, sister, housemate or playmate been diagnosed with blood lead poisoning? .... Y N

TB RISK

30. Does your child live with, or have a greater than once a week contact with an adult with known tuberculosis? .... Y N
31. Is your child a recent adoptee from an area that has a high frequency of tuberculosis? (Asia, Middle East, Africa, Latin America) .... Y N
32. Has your child tested positive for the AIDS virus? .... Y N
33. Is your child exposed on a regular basis (more than twice a week) to anyone infected with AIDS; homeless; in a nursing home, prison or group home; or IV drug user? Y N
34. Is your child living in a home with foster children or is he/she a foster child? .... Y N
35. Did you (parent) or anyone else your child lives with move in the last five years from anywhere in Asia, Middle East, Africa or Latin America? .... Y N
36. Does your child have any of the following chronic medical problems: Diabetes, Renal (kidney) failure, or Malnutrition? .... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date