



Lucile Packard
Children's Hospital
Stanford

Lucile Salter Packard Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304



Questionnaire • Well Child Check 2 1/2 Year

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Patient Name:

Date of Birth:

Well Child Check: 2 1/2 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No Yes
Has your child had any reactions to vaccinations in the past? No Yes

Development: Can/Does your child (check all that apply) –

_ throw a ball overhand? _ say more than 150 words?
_ jump in place (both feet off the ground)? _ use pronouns (I, you, me)?
_ run? _ climb? _ walk up/down stairs? _ show interest in potty training?
_ talk and be at least 50% understandable to a stranger? _ understand directions?

Do you and your child read together daily? Yes No

Who provides daytime care for your child? _____

Nutrition/Elimination/Physical Activity:

What type of milk does your child drink? _____ How much per day? _____ cups

How much yogurt per day? _____ How much cheese per day? _____

What dietary restrictions does your child have, if any? _____

Is your child eating 4 servings per day of a variety of fruits and vegetables? Yes No

Does your child eat iron-rich foods (meat, iron-fortified cereal, or beans)? Yes No

How much juice or sweet beverages does your child drink in a day? _____ oz

Does your child eat junk/fast food more than twice per week? No Yes

Are there any problems with pooping or peeing? No Yes

Does your child play actively most days of the week? Yes No

Your child's medications/vitamins/supplements: _____

Dental Health:

Does your child see a dentist every 6 months? Yes No

Does your child (with your help) brush his/her teeth daily? Yes No

Sleep:

How long does your child sleep at night? _____ hours

How long does your child nap? _____ hours

Staying Healthy/Safety:

Does your child get any screen time? No Yes

Does your home have a working smoke detector? Yes No

Is your water temperature set to less than 120 degrees? Yes No N/A

Is your child always supervised when near water, including the bathtub? Yes No

Do you have safety guards on upper floor windows and gates for the stairs? Yes No N/A

Does your home have cleaning supplies/medicines/matches locked away? Yes No

Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes No

Does your child use sun protection when outdoors? Yes No



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Questionnaire • Well Child Check 2 ½ Year

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Is your car seat appropriately sized and in the back seat?	Yes	No	
Do you always check for children before backing your car out?	Yes	No	
Does your child wear a helmet when riding anything with wheels?	Yes	No	N/A
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your baby spend time with anyone who smokes or vapes?	No	Yes	

Please list any new major family medical issues:

Who lives in the home with your child?

What international travel has your child had since their last well check? (where and how long)

What plans are there for international travel with your child in the next 12 months? (where and how long)

What concerns would you like to discuss today?
