Parent / Guardian Questionnaire (1-2 year old)

Pediatric Specialists of the Northwest

Child's name: _____ Date of birth: _____ Date completed: _____

Your name: _____ Relation to child: _____

Check, circle, or complete all of which apply to your child

DAILY ACTIVITY and ROUTINE

Childcare or Daycare ☐ Yes ☐ No

I read to my child _____days/week

My child:

Gets _____ naps / day for a total of _____ hrs / day

Goes to bed **inconsistently / consistently** at _____ pm

Gets _____ hours of sleep *on average* each night

Screen time (i.e. TV, computer) _____ hrs / day

Playtime _____ hrs / day

NUTRITION and BOWEL HABITS

Daily intake:

Milk _____ oz / day

Dairy (yogurt, cheese, other) _____ servings / day

Meat, poultry, fish, eggs & nuts _____ servings / day

Vegetables _____ servings / day

Fruits _____ servings / day

Bread, cereal, rice & pasta _____ servings / day

Fluoridated water ☐ Yes ☐ No ☐ Unsure

Supplement: ☐ vitamin ☐ iron ☐ Other _____

Soda or pop _____ oz / day **Juice** _____ oz / day

Fast food _____ times / week **Junk food** _____ times / day

Concerns about bowel movements / urination ☐ No ☐ Yes

SOCIAL HISTORY

In the past year, have there been any changes or challenges in your family?

☐ Marriage ☐ Loss of job ☐ Births
☐ Separation ☐ Move to a new neighborhood ☐ Serious illness
☐ Divorce ☐ Deaths

☐ Other: _____

_____

☐ No interval changes

Does your child live with or spend time with anyone who uses tobacco or smokes? ☐ No ☐ Yes

FAMILY HISTORY

Have you or any of your child's relatives developed new medical problems since your last visit? ☐ No ☐ Yes

Check all that apply

HOW WOULD YOU BEST DESCRIBE YOUR CHILD

☐ Happy ☐ Friendly ☐ Quiet, Timid ☐ Pays attention ☐ Poor self-control
☐ Active ☐ Sad ☐ Cries easily ☐ Hyperactive ☐ Initiates physical fight
☐ Impulsive ☐ Tired, Fatigue ☐ Fears new situations ☐ Separation anxiety

☐ Speech delay ☐ Sleep problems ☐ Stereotypic habit
☐ Social communication delay ☐ Temper tantrums Nail biting, thumb sucking, hair pulling
☐ Other concern: Head banging, body rocking

Reviewed and discussed by _____, MD/DO Date: _____

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Your name: _____ Relation to child: _____

Lead Risk Assessment – Circle the appropriate response			
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	YES	NO	DON'T KNOW
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	YES	NO	DON'T KNOW
3. Does this child live in or regularly visit a home built before 1978?	YES	NO	DON'T KNOW
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	YES	NO	DON'T KNOW
5. Is this child a refugee or an adoptee from any foreign country?	YES	NO	DON'T KNOW
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e. China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	YES	NO	DON'T KNOW
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	YES	NO	DON'T KNOW
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	YES	NO	DON'T KNOW
9. Does this child reside in a high-risk zip code area? (see attached table of zip codes)	YES	NO	DON'T KNOW

Tuberculosis Assessment – Circle the appropriate response			
1. Was your child born in a country/continent at high risk for tuberculosis?	YES	NO	DON'T KNOW
2. Has your child traveled for longer than 1 week to Africa, Asia, Latin America, or Eastern Europe?	YES	NO	DON'T KNOW
3. Has a family member or contact had tuberculosis or a positive tuberculin skin test?	YES	NO	DON'T KNOW
4. Does your child spend any time with anyone who has been in jail, uses illegal drugs, or has HIV?	YES	NO	DON'T KNOW

Additional Questions and Concerns (i.e. development, learning, behavior, etc…)

1)

2)

3)

4)

5)

Reviewed and discussed by _____, MD/DO Date: _____