Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

30 Month Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

_____

_____

_____

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

Has your child seen a dentist in the last 6 months: **Yes No**

How many times a day does your child brush their teeth? ___ How many times a day do they floss? ___

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other: _____**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

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GENERAL HEALTH

What type of milk does he/she drink? **Whole 2% 1% Fat free Lactose free Soy**

How much milk/formula does he/she drink in a day? **< 8oz 8-16 oz 16-24 oz 24-32oz > 32oz**

What else does he/she drink and how many glasses a day does he/she drink? **___ Glasses of juice**

___ Glasses of water ___ glasses of caffeinated soda or tea ___ glasses of decaffeinated soda or tea

Does your child drink from: **cup bottle only cup and bottle phasing out bottle**

Does your child eat: **table foods adequate fruits/vegetables meat whole grains**

Does your child have any problems with bowel movements, including constipation or diarrhea? **Yes No**

Is he/she toilet trained? **Yes Daytime only In process No**

Does he/she have any problems sleeping? **Yes No** If yes, what kind of problems? _____

How would you describe your child's temperament? **Happy Fussy Easy Demanding**

Cries when hungry or with needs Fussy all the time Fussy at night Fussy but consolable

Do you have any concerns about:

Your child's development? **Yes No**

Your child's behavior? **Yes No**

HEARING

Do you concerns about how your child hears? **Yes No**

Do you have concerns about how your child speaks? **Yes No**

VISION

Do you have any concerns about how your child sees **Yes No**

Does your child hold objects close when trying to focus? **Yes No**

Do you child's eyes appear unusual or seem to cross, drift, or be lazy? **Yes No**

Do your child's eyelids droop or does one eyelid tend to close? **Yes No**

Have your child's eyes ever been injured? **Yes No**

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Check off each task that your child is able to do:

- ☐ Walks up steps
- ☐ Throws overhand
- ☐ Kicks ball
- ☐ Runs well
- ☐ Jumps
- ☐ Balances on 1 foot for 1 second
- ☐ Removes clothing
- ☐ Stacks 4-6 objects
- ☐ Makes horizontal and circular strokes with a crayon
- ☐ Brushes teeth with help
- ☐ Uses spoon well
- ☐ Combines words
- ☐ Follows 2 part commands
- ☐ 20-50+ words
- ☐ Names 6 body parts
- ☐ Understands cold, tired, hungry
- ☐ Gives first and last name
- ☐ Knows short from long
- ☐ Names picture (cat, dog, bird)
- ☐ Pretend play
- ☐ Parallel play
- ☐ Helps with simple tasks
- ☐ Puts clothes on
- ☐ Washes/dries hands
- ☐ Brushes teeth
- ☐ Separates easily from parents

GENERAL SAFETY

Does your child always use a car seat? **Yes No**

Is your home childproofed? **Yes No**

Do you have these things in your home:

Smoke detector **Yes No**

Carbon monoxide detector **Yes No**

Fire extinguisher **Yes No**

FAMILY HISTORY:

Is there any history in the child's family of:

Heart disease **Yes No**

High Cholesterol **Yes No**

Overweight or Obesity **Yes No**