HOLYOKE PEDIATRIC ASSOCIATES, LLP

Pre-Visit Questionnaire
Two Year Visit

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? _____

_____

_____

_____

Questions about your child.

Have any of your child's relatives developed new medical problems since your last visit?

❑ Yes ❑ No ❑ Unsure If yes, please explain: _____

_____

Hearing	Do you have any concerns about how your child hears?	❑ Yes	❑ No	❑ Unsure
	Do you have any concerns abouth how your child speaks?	❑ Yes	❑ No	❑ Unsure
Vision	Do you have concerns about how your child sees?	❑ Yes	❑ No	❑ Unsure
	Does your child hold objects close when trying to focus?	❑ Yes	❑ No	❑ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	❑ Yes	❑ No	❑ Unsure
	Is there a family history of strabismis (eye crossing or lazy eye)?	❑ Yes	❑ No	❑ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	❑ Yes	❑ No	❑ Unsure
	Have your child's eyes ever been injured?	❑ Yes	❑ No	❑ Unsure
* LEAD	Does your child have a sibling or playmate that has had lead poisoning?	❑ Yes	❑ No	❑ Unsure
	Does you child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	❑ Yes	❑ No	❑ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	❑ Yes	❑ No	❑ Unsure
* Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	❑ Yes	❑ No	❑ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	❑ Yes	❑ No	❑ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	❑ Yes	❑ No	❑ Unsure
	Is your child infected with HIV?	❑ Yes	❑ No	❑ Unsure
* Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	❑ Yes	❑ No	❑ Unsure
	Does your child have a parent with high blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	❑ Yes	❑ No	❑ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	❑ Yes	❑ No	❑ Unsure

Over -

Have there been any major changes in your family lately? ❑ No ❑ Yes

❑ *Move* ❑ *Separation* ❑ *Divorce* ❑ *Death in the family* ❑ *Job change* ❑ *Other* _____

* Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ❑ Yes ❑ No

Does your child have any special health care needs? ❑ Yes ❑ No If yes, please explain: _____

_____

* List your child's current medications and doses: Include any herbs, vitamins or supplements: _____

_____

_____

_____

* What is the best way to contact you (please circle): home phone / cell phone / work phone: _____

* Would you like to share your email address? _____