Patient Name_____Date of Birth_____

# Risk Assessment 2 Year

| | | | | |
|---|---|---|---|---|
| Any relatives developed new medical Problems since your last visit | No | Yes | Unknown | Comment _____ |
| Concerns about how child hears | No | Yes | Concerns | |
| Concerns about how child speaks | No | Yes | Concerns | |
| Concerns about how child sees | No | Yes | Concerns | |
| Any concerns for crossing, drifting or lazy eyes | No | Yes | Comment | |
| Have any members of the family or your Child's playmates had high blood lead | No | Yes | Unknown | Comment |
| Does child live/visit house built before 1978 currently being renovated | No | Yes | Unknown | Comment |
| Does child live/visit a house/apartment building built before 1950 | No | Yes | Unknown | Comment |
| Born in country outside of the United States | No | Yes | Unknown | Comment |
| Traveled or had contact with high TB risk populations longer than a week | No | Yes | Unknown | Comment |
| Family member or contact had tuberculosis or positive TB skin test | No | Yes | Unknown | Comment |
| Is the child HIV Infected | No | Yes | Unknown | Comment |
| Parents or grandparents have stroke or heart problems before age 55 | No | Yes | Comment | |
| Parent has elevated cholesterol (>240mg/dl) or is taking cholesterol medication | No | Yes | Comment | |
| Diet includes iron-rich foods such as meat, eggs, iron fortified cereal, or beans | Yes | No | Comment | |
| Do you have a dentist for your child | Yes | No | Comment | |
| Primary water source contains fluoride | Yes | No | Comment | |
| Reads with child everyday | Yes | No | Comment | |
| Parent can understand what child wants | Yes | No | Comment | |
| Child plays with other children | Yes | No | Comment | |

| | | | |
|---|---|---|---|
| Has encouraged toilet training | Yes | No | Comment |
| Is child interested in using the toilet | Yes | No | Comment |
| Always uses car seat in back seat of car | Yes | No | Comment |
| Always watches child when outside playing | Yes | No | Comment |
| Keeps child away from moving machines, Lawn mowers, driveways, and streets | Yes | No | Comment |
| Wears helmet when riding tricycle, motorized kid car, or in seat of adult bike | Yes | No | Comment |
| Have a gun in the home, or any home child spends time | No | Yes | Comment |
| If so are guns unloaded and locked away | Yes | No | N/A |
| Does anyone smoke around child | No | Yes | Comment |

| | | | | |
|---|---|---|---|---|
| Servings of fruits & vegetables each day | More than 4 per day | 3-4 per day | 1-2 per day | 0-1 per day |
| Eats out each week | 0-1 time per week | 1-2 times per week | 3-4 times per week | More than 4 times per week |
| Activity level | More than 60 Minutes per day | 30-60 minutes per day | Less than 30 minutes per day | Not very often |
| Sweet drinks per day | Not very often | 1 per day | 2per day | More than 3 per day |
| Watches TV or spends time on computer/ Video games | Not very often | 30-60 Minutes per day | 1-2 hours per day | More than 2 hours per day |

## 2 Year Development

| | | | |
|---|---|---|---|
| Stacks 5 or 6 small blocks | Yes | No | Comment |
| Kicks a ball | Yes | No | Comment |
| Walks up and down stairs 1 step at a time alone while holding wall or railing | Yes | No | Comment |
| Can point to at least 2 pictures that you name when reading a book | Yes | No | Comment |
| Throws a ball overhand | Yes | No | Comment |
| Names 1 picture such as; cat, dog, or ball | Yes | No | Comment |
| Jumps up | Yes | No | Comment |
| Copies things that you do | Yes | No | Comment |
| Follows 2-step commands | Yes | No | Comment |
| When talking outs 2 words together like “my book” | Yes | No | Comment |
| Plays pretend | Yes | No | Comment |
| Plays alongside other children | Yes | No | Comment |

**GWINNETT PEDIATRICS & ADOLESCENT MEDICINE**

Child's Name: _____

Date of Birth: _____

Today's Date: _____

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g. you've seen it once or twice), please answer as if the child does not do it.

| | | |
|---|---|---|
| 1. Does your child enjoy being swung, bounced on your knee, etc.? | YES | NO |
| 2. Does your child take an interest in other children? | YES | NO |
| 3. Does your child like climbing on things, such as up stairs? | YES | NO |
| 4. Does your child enjoy playing peek-a-boo/hide-and-seek? | YES | NO |
| 5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things? | YES | NO |
| 6. Does your child ever use his/her index finger to point, to ask for something? | YES | NO |
| 7. Does your child ever use his/her index finger to point, to indicate interest in something? | YES | NO |
| 8. Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them? | YES | NO |
| 9. Does your child ever bring objects over to you (parent) to show you something? | YES | NO |
| 10. Does your child look you in the eye for more than a second or two? | YES | NO |
| 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) | YES | NO |
| 12. Does your child smile in response to your face or your smile? | YES | NO |
| 13. Does your child imitate you? (e.g., you make a face-will your child imitate it?) | YES | NO |
| 14. Does your child respond to his/her name when you call? | YES | NO |
| 15. If you point at a toy across the room, does your child look at it? | YES | NO |
| 16. Does your child walk? | YES | NO |
| 17. Does your child look at things you are looking at? | YES | NO |
| 18. Does your child make unusual finger movements near his/her face? | YES | NO |
| 19. Does your child try to attract your attention to his/her own activity? | YES | NO |
| 20. Have you ever wondered if your child is deaf? | YES | NO |
| 21. Does your child understand what people say? | YES | NO |
| 22. Does your child sometimes stare at nothing or wander with no purpose? | YES | NO |
| 23. Does your child look at your face to check your reaction when faced with something unfamiliar? | YES | NO |
| 24. Have you ever filled out this form for this child before? | YES | NO |