

**Twenty Four Month Well Child Visit
Parent Questionnaire**

1. Child's water source: City Well Bottled

2. How often do you brush your child's teeth? _____ Seen by a dentist? Yes/No

3. Are you aware of potential choking hazards (foods, coins, jewelry)? Yes/No

4. Have you switched from whole milk to low-fat milk? Yes/No

5. Is your child offered 2-3 nutritious snacks and 3 regular meals daily? Yes/No

6. Are you in the process of toilet-training your child? Yes/No

7. Do you have a routine for putting your child to sleep? Yes/No

8. Do you read to your child? Yes/No

9. Do you try to regulate your child's television-watching (time, content)? Yes/No

10. Are there any smokers in the household? Yes/No

11. Is there is a gun in the home? Yes/No

12. Does your home have working smoke detectors? Yes/No

13. Do you ever leave your child alone in the bathtub? Yes/No

14. Have you checked the temperature of the hot water where you live? Yes/No

15. Do you keep the handles of pots and pans on the stove out of the reach of your child? Yes/No

16. How is your child restrained when he/she rides in a car?

17. How do you discipline your child?

18. Have you installed: Window Guards Stair Gate Kitchen Gate
 Fire Extinguisher Outlet Covers Cabinet Locks

19. Do you fear for the safety of yourself or members of your family? Yes/No

20. What questions do you have for your child's provider today?