**TODDLER REVIEW OF SYSTEMS**

**(18 months – 2½ years)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**Please check (√) the statements that apply to your child.**

* One or both parents’ smoke.
* There has been a serious illness in the past.
* There was a problem with the mother’s pregnancy, the child’s birth and/or the period shortly after birth (i.e., the baby had to stay in the hospital after the mother went home).
* There is a present concern about my child’s overall health.
* Do you wonder if immunizations are up to date?
* There was a bad reaction to an immunization.
* Do you wonder about vitamins or fluoride?
* There is a possible allergy to certain foods, medications and/or environmental stimuli (i.e., dust, pollen).
* Our child does not eat 3 meals a day.
* There is a concern about a balanced diet (i.e., the 4 food groups – milk products, fruits and vegetables, breads and cereal, meat, chicken and fish).
* Our child snacks on too many sweets, including beverages.
* It is hard to get our child to brush his/her teeth.
* There is a question about toilet training.
* Our child has difficulty with running, walking and/or coordination.
* Our child has difficulty feeding him/herself, using silverware and/or a cup.
* Our child does not participate in dressing him/herself.
* Our child does not play well with other children or adults.
* We are concerned about our child’s speech.
* Our child is afraid of new situations.
* Our child is uncooperative.
* We are concerned about our child’s temper tantrums.
* Our child seems to have unusual fears or is unhappy.
* There is a concern about sleeping or napping.
* There is a concern about safety both inside and/or outside the child’s home.
* We do not have the Poison Control Number near our telephone.
* There has been recent weight loss or recurrent illness.
* There is a problem with eyes, vision, ears or hearing.
* Our child frequently has a runny or stuffy nose.
* There is a problem with headaches.
* There is a lump or swelling that is of concern.
* There is a question about rashes, sores, pimples or birthmarks.
* There is a history of seizures (convulsions).
* There is a concern about coughing, wheezing, or breathing.
* We have been told that our child has a problem with his/her heart or lung
* There is a concern with bowel movements (too soft, too hard, etc.).
* Our child’s urine looks too dark, smells too strong, seems too often and/or causes pain.
* There is a concern about our child’s feet, legs and/or hips.
* There is a family or marital problem.
* Someone close to our child is seriously ill or has recently died.
* Sometimes one of the child’s parents seems too strict.
* Sometimes one of the child’s parents has difficulty disciplining the child.
* The mother or father does not have enough time to spend with the child.
* There are other problems this questionnaire did not address.
* I (We) wish to talk to the doctor or nurse practitioner about a confidential matter.
* Our child is currently seeing other health care providers (physicians, physical and/or speech therapy, etc.) or using other health related agencies (i.e., well child clinics, Broome Developmental Center, etc.).
* Our child has had the chickenpox.