Olive Branch Pediatrics

3105 West 15th Street, Suite D
Plano, Texas 75075
P: 972.867.2869 | F: 972.964.5219
www.olivebranchpediatrics.com

Review of Systems

Please place a check mark next to any of the following symptoms that apply to the patient's current health.

General:
Fever _____
Fatigue _____
Weight Loss _____

Eyes:
Blurred Vision _____
Eye Pain _____
Glasses _____

Ear/Nose/Throat:
Ear Pain _____
Decreased Hearing _____
Nosebleeds _____
Nasal Congestion _____
Runny Nose _____
Sore Throat _____
Hoarseness _____
Difficulty Swallowing _____

Respiratory:
Cough _____
Wheezing _____
Shortness of Breath _____

Cardiovascular:
Heart Murmur _____
Chest Pain _____
Irregular Heart Beat _____
Blood Pressure Problem _____

Gastrointestinal:
Abdominal Pain _____
Nausea _____
Vomiting _____
Diarrhea _____
Constipation _____
Blood in Stool _____
Heartburn _____

Genitourinary:
Pain with Urination _____
Blood in Urine _____
Frequent Urination _____
Bedwetting _____

Endocrine:
Hair Loss _____
Cold/Heat Intolerance _____
Abnormal Period _____

Skin:
Rash _____
Acne _____

Hematology:
Easy Bleeding _____
Easy Bruising _____
Anemia _____

Musculoskeletal:
Bone Pain _____
Back Pain _____
Swollen Joint _____
Muscle Pain _____

Neurological:
Headache _____
Seizures _____
Dizziness _____
Numbness _____

Allergic:
Food Allergy _____
Medication Allergy _____

ASQ-3

24 Month Questionnaire

23 months 0 days through 25 months 15 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(She needs to identify only one picture correctly.)*	○	○	○	___
2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	___
3. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	○	○	○	___

- ○ a. "Put the toy on the table."
- ○ b. "Close the door."
- ○ c. "Bring me a towel."
- ○ d. "Find your coat."
- ○ e. "Take my hand."
- ○ f. "Get your book."

4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	○	○	○	___
5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? *(Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")* Please give an example of your child's word combinations:	○	○	○	___

COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	○	○	○	___

COMMUNICATION TOTAL ___

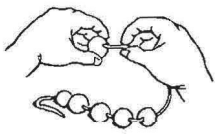
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	___
2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	○	○	○	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall. 	○	○	○	___
4. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	___
5. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	___
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	___ *

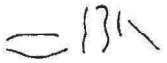
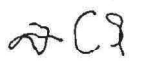
GROSS MOTOR TOTAL ___

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

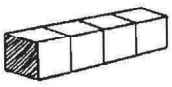
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	○	○	○	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	○	○	○	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
4. Does your child flip switches off and on?	○	○	○	___
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	___
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? *(Do not show him how.) (You can use a soda-pop bottle or baby bottle.)*	○	○	○	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	○	○	○	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	○	○	○	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	___
3. Does your child eat with a fork?	○	○	○	___
4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	○	○	○	___
5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	___
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ○ YES ○ NO

OVERALL *(continued)*

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ○ YES ○ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

6. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

8. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

9. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ (*Modified Checklist for Autism in Toddlers Revised*)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No

Olive Branch Pediatrics

3105 West 15th Street, Suite D
Plano, Texas 75075
P: 972.867.2869 | F: 972.964.5219
www.olivebranchpediatrics.com

Tuberculosis Questionnaire

Please check the box below that matches your answer:

	Yes	No	Don't Know
1. Has your child ever been tested for TB? If yes, when? _____			
2. Have your ever been told that your child had a positive tuberculin skin or other tuberculosis test? If yes, when? _____			
3. Has your child been around anyone who has had an unexplained prolonged fever, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood?			
4. Has your child been around anyone sick with tuberculosis?			
5. Was your child born in another part of the world such as Mexico, Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
6. Has your child been to Mexico, Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than three weeks?			
7. Has your child been around anyone who uses needles for illicit drug use, has AIDS or HIV, was recently in jail or prison, is homeless, or has just come to the US from a different country?			

Olive Branch Pediatrics

3105 West 15th Street, Suite D
Plano, Texas 75075
P: 972.867.2869 | F: 972.964.5219
www.olivebranchpediatrics.com

Lead Risk Questionnaire

Please check the appropriate box next to each question below.

	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?		
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?		
3. Does your child eat or chew on non-food things like paint chips or dirt?		
4. Does your child have a family member or friend who has or did have an elevated blood lead level?		
5. Is your child a newly arrived refugee or foreign adoptee?		
6. Does your child come in contact with an adult whose job or hobby involves lead exposure? Examples • House construction or repair • Battery manufacturing or repair • Burning lead-painted wood • Automotive repair shop or junk yard • Going to a firing range or reloading bullets • Chemical preparation • Valve and pipe fittings • Brass/copper foundry • Refinishing furniture • Making fishing weights • Radiator repair • Pottery making • Lead smelting • Welding		
7. Does your family use products from other countries such as pottery, health remedies, spices, or food? Examples • Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda • Cosmetics such as kohl, surma, and sindor • Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins. • Foods canned or packaged outside the U.S.		