Well Child Visit: 24 Months

Name: _____ **DOB:** _____ **Date:** _____

Current Medications	Drug / Food Allergies	Accompanied By

Age □ M □ F	Ht.	Wt.	BMI and %ile	HC	HR	Temp.	Interpreter: Y / N

Past Medical History

Recent illness: □ Yes □ No _____
_____
_
Child has dental home: □ Yes □ No _____
F/u previous concern: □ None _____
_____
_

Interval History

Sleep: □ NL_____
□ Bedtime routine
Elimination: □ NL _____
Behavior: □ NL _____
Play time >60 mins/day: □ Yes □ No ____
Screen time <2hr/day: □ Yes □ No _____

Nutrition

□ Milk: _____ # oz/day :_____
Fruits: □Yes □ No _____
Vegetables: □Yes □ No_____
Meats: □ Yes □ No ___ Vitamins: □ Yes □ No
Healthy snacks: □ Yes □ No Juice: □ Yes □ No
Concerns:_____

Social / Family History

Lives at home with:_____
Parent / child interaction: □ Yes □ No _____
Tobacco smoke exposure: □ Yes □ No_____
Parents working outside home: □ Mother □ Father
Child care: □ Yes □ No Type: _____
Family / work balance: □ Yes □ No_____
WIC: □ Yes □ No _____

Growth-Development

□ Autism-specific screening: □ NL Tool_____

Cognitive: □ NL _____
- Names 1 picture (dog, ball, etc.); follows 2-step command

Language: □ NL _____
- Uses 2 word phrases; asks parent to read book; >50 word vocabulary

Physical: □ NL _____
- Stacks 5-6 blocks; can turn book pages one at a time

Social: □ NL _____
- Parallel play; ↑ pretend play; refers to self as "I" or "me"

Parental concerns: _____

Physical Exam (checked □ = normal)

□ **General** (Alert, NAD, socialization NL)
□ **Head** (No deformities, symmetric)
□ **Eyes** (PERRL, EOMI, + RR, cover test, lids NL, conjunctivae/sclera clear)
□ **Ears** (Canals clear, TMs normal, orients to sounds, voice)
□ **Nose** (Mucosa NL, septum NL, patent)
□ **Mouth/Throat** (MMM, palate intact, lips & tongue NL, no oral lesions, no erythema)
□ **Teeth** (Gums NL, dentition NL, no staining, caries or white spots)
□ **Heart** (No murmurs, femoral pulses)
□ **Lungs** (Clear breath sounds)
□ **Abdomen** (Soft, non-tender)
□ **Skin** (No rashes, no lesions)
□ **Neuro** (Tone, symmetry, strength & gait NL)
□ **Extremities** (Full ROM, strength/tone NL, no hip dysplasia)
□ **Genitalia**
Male (Penis NL: circ/uncir, no adhesions)
Female (Labia/clitoris NL, no discharge)

Abnormal Findings

Assessment

□ Well child
□ Normal growth and development
□ IMMS UTD
□ IMMs due _____

Anticipatory Guidance

□ **Behavior** (Consistent discipline, temper tantrums, encourage play with other children, self-expression)
□ **Safety** (Bike helmet, car seats, second hand smoke, burns, smoke detectors, drowning, poisoning, supervise)
□ **Health Promotion** (Family meals, healthy snacks, limit juice, brush teeth, hand washing, daily physical activity, limit TV/screen time)
□ **Development** (Toilet training, playtime, follow 1-2 step commands, read every day, model language, listen and respond to child, sing)

Plan

□ Autism-specific screening
□ Lead screening #2
□ Dental fluoride varnish every 3-6 mos. either primary care or dental office
□ Fluoride supplementation risk assessment
□ TB testing based on risk factors
□ Iron Deficiency Anemia risk assessment
□ Dyslipidemia risk assessment
□ Education handout given
□ Immunizations (See immunization record)

Next Appointment: _____ **Signature:** _____ **Date:** _____

Well Child Visit: 24 Months

Name: _____ **DOB:** _____ **Date:** _____

Notes:

Next Appointment: _____ **Signature:** _____ **Date:** _____