Well Child Visit: 24 Months

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

Current Medications	**Drug/Food Allergies**	**Accompanied By**

Age □M □F	**Ht.**	**Wt.**	**BMI**	**BMI %ile**	**HC**	**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_____

Growth-Development

□ Autism-specific screen: □NL Tool_____

Cognitive: □ NL _____

- Names 1 picture (dog, apple, 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, 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

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

□ Education handout given
□ Immunizations (See immunization record)
□ Lead screen
□ Dental referral

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