## PEDIATRIC VISIT 2 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI_____/_____%HC_____% TEMP_____

### HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

### PSYCHOSOCIAL ASSESSMENT:

**Sleep:** **Child care:**

**Recent changes in family:** *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

**Environment:** Smokers in home? Yes / No

**Violence Assessment:**
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

### RISK ASSESSMENT: CHOL TB LEAD

(By questionnaire) Pos / Neg Pos / Neg Pos / Neg
Testing/counseling, if risk assessment is positive_____
_____

### PHYSICAL EXAMINATION:(unclothed)

| Wnl | Abn | *(describe abnormalities)* |
|---|---|---|
| ☐ | ☐ | Appearance/Interaction |
| ☐ | ☐ | Growth |
| | | _____ |
| ☐ | ☐ | Skin |
| | | _____ |
| ☐ | ☐ | Head/Face |
| ☐ | ☐ | Eyes/Red reflex/Cover test |
| ☐ | ☐ | Ears |
| ☐ | ☐ | Nose |
| ☐ | ☐ | Mouth/Gums/Dentition |
| | | _____ |
| ☐ | ☐ | Neck/Nodes |
| ☐ | ☐ | Lungs |
| | | _____ |
| ☐ | ☐ | Heart/Pulses |
| ☐ | ☐ | Chest/Breasts |
| | | _____ |
| ☐ | ☐ | Abdomen |
| ☐ | ☐ | Genitals |
| | | _____ |
| ☐ | ☐ | Extremities/Hips/Feet |
| ☐ | ☐ | Neuro/Reflexes/Tone |
| | | _____ |
| ☐ | ☐ | Vision *(gross assessment)* |
| ☐ | ☐ | Hearing *(gross assessment)* |

### NUTRITIONAL ASSESSMENT:

**Typical diet:** *(specify foods)*:

**Education:** Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐
Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐

### DEVELOPMENTAL SCREENING: *( Standardized Tool Required))*

**ASQ:** ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
**Results:** **Pass/Fail**
**MCHAT : (Required)** ☐ **Pass /Fail Referred? Where**_____
☐ **Areas of Concern**:_____
**Referred:** Yes / No **Where**? _____

### DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

**Social:** Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐
Washes and dries hands ☐ Plays interactive games ☐
Separates from mother ☐

**Fine Motor:** Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐
Uses spoon well ☐

**Language:** Combines 2 words ☐ Knows 3-5 named body parts ☐
Follows 2 part directions ☐ Understands cold, tired, hungry ☐
Gives first and last name ☐ Picks longer line ☐
Names 1 picture (cat, bird, horse, dog, person) ☐

**Gross Motor:** Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐
Balances on 1foot-1 second ☐ Pedals tricycle ☐
Throws ball overhand ☐

### ANTICIPATORY GUIDANCE: *(Check all that were discussed)*

**Social:** Aware of self/different from others ☐ Needs peer contact ☐
Dawdling is normal ☐ Resolving negativism ☐
Power struggles occur ☐

**Parenting:** Toilet training (relaxed, praise success) ☐ Sexuality ☐
Help teach self-control ☐ Offer choice, give simple tasks ☐
Tantrums (ignore, distract, sympathize) ☐

**Play and communication:** Small table and chairs ☐
Stories and music ☐ Building materials ☐

**Health:** Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐
Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐
Physical activity ☐ Second hand smoke ☐ Tick prevention ☐

**Injury prevention:** Car seat ☐ Rear riding seat ☐ Poison control # ☐
Hot water at 120º ☐ Water safety (tub, pool) ☐ Toddler proof home ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐

### PLANS

1. Review immunizations and bring up to date ☐ _____
2. Second Lead/HCT test required ☐ if not completed at 24 month visit_____
3. Dental visit advised ☐ Date of Last Dental Exam _____
4. Fluoride Varnish Applied? Yes / No_____
5. Next preventive appointment at 3 Years ☐ _____
6. Referrals for identified problems? *(specify)* _____

**Signatures:**_____