

**PEDIATRIC VISIT 2 YEARS**

DATE OF SERVICE \_\_\_\_\_

NAME \_\_\_\_\_

M / F

DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ / \_\_\_\_\_ %

HEIGHT \_\_\_\_\_ / \_\_\_\_\_ %

BMI \_\_\_\_\_ / \_\_\_\_\_ %

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**

(Circle) Pos / Neg Pos / Neg Pos / Neg

**PHYSICAL EXAMINATION:**

Wnl	Abn	<i>(describe abnormalities)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Gums/Dentition
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision <i>(gross assessment)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing <i>(gross assessment)</i>
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

Signatures: \_\_\_\_\_

**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:** *(With Standardized Tool)*  
REQUIRED

ASQ:  PEDs  Other:  *(specify)* \_\_\_\_\_

Results: Wnl  Areas of Concern: \_\_\_\_\_

Referred: Yes / No Where? \_\_\_\_\_

MCHAT Required

**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 120°  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  \_\_\_\_\_

3. Speech referral if delayed  \_\_\_\_\_

4. PPD, if risk assessment is positive  \_\_\_\_\_

5. Dental visit advised  Date of Last Dental Exam \_\_\_\_\_

6. Testing/counseling, if cholesterol risk assessment is positive \_\_\_\_\_

7. Fluoride Varnish Applied? Yes / No \_\_\_\_\_

8. Next preventive appointment at 30 Months  \_\_\_\_\_

9. Referrals for identified problems? *(specify)* \_\_\_\_\_