PEDIATRIC VISIT 30 MONTHS

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

(*If not done at 2yr. visit) Pos / Neg Pos / Neg Pos / Neg

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: *(With Standardized Tool)*

REQUIRED (*if failed or not completed at 24 month visit)
ASQ: ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____
Results: **Pass/Fail** **Areas of Concern**:_____
Referred: Yes / No **Where**? _____
MCHAT: Required ☐ ***** *if failed or not completed at 24 month visit)*

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 2yr. visit____
3. Speech referral if delayed ☐ _____
4. PPD, if risk assessment is positive ☐ _____
5. Dental visit advised ☐ or 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 3 Years ☐ _____
9. Referrals for identified problems? *(specify)* _____

Signatures:_____