VACCINES: P C

WELL CHILD 2 YEARS

Today's Date:________________

Patient Name:______________________________ Date of Birth:__________________

FAMILY HISTORY:
Changes in household since last visit ___Yes/No Explain__________________________________
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent ___ Other________________
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare ___Other________________

NUTRITION:
1. Does your child have any recurrent problems with development, special diet, weight gain/loss, refusal of any food group, stomach problems or anemia? ___Yes/No (circle any that apply, explain below)
   List: ____
2. Usual number of servings per day: 1,2,3
   ___Dairy ___Formula ___Breast
   ___Bread, cereal, rice and pasta
   ___Meat, poultry, fish, eggs and dry beans ___Vegetables ___Fruits

CHILD HEALTH: Indicate Yes or No and Check ☑ any that apply.
1. Does your child have any food or drug allergies? ___ Yes/No List____
2. Has your child had any major illness, surgeries, injuries or hospitalizations? _______Yes/No
   List:____
3. Does your child have any physical problems? ____Yes/No ___Low Weight Gain ___Weight Loss ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other____________________________________
4. Does your child take any medications regularly? _______Yes/No ____
5. Has your child seen a dentist or scheduled for a dental appointment? _____Yes/No

IMMUNIZATIONS: Check ☑ Yes or No
___**Yes** ___**NO** Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY: Indicate Yes or No
Vision Screen:
1. Does your child seem to see well? _____Yes/No
2. Do your child's eyes appear to cross, drift or seem lazy? ___Yes/No Explain________________________________
3. Do your child's eyes appear unusual? ___Yes/No Explain____

Hearing Screen:
1. Does your child use his/her voice most of the time to get what he/she wants or to communicate? _____Yes/No
2. Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Uses spoon ______Yes/No
2. Builds tower of 2 cubes/blocks _____Yes/No
3. Combines 2 words _____Yes/No
4. Follows 2-part directions _____Yes/No
5. Kicks ball forward _____Yes/No

MENTAL HEALTH: Check ☑ any that apply.
Feelings: ___Appropriate for age ___Cries Excessively ___Cries too little ___Angry ___Sad ___ Fearful ___ Sullen ___Anxious
Social Interaction: ___Appropriate for age ___Withdrawn ___Clings excessively
Thinking: ___Appropriate for age ___ Problems Concentrating ___Distracted ___Mistrustful
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ____Yes/No
Explain: ____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check here ☐ if no problems noted.
Skin: ___rashes ___infections
Eyes: ___Eye Discharge ___Deviation ___Excessive Tearing ___Wandering eye movement
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge ___Sore throat
Cardio: ___History of murmur
Respiratory: ___Trouble Breathing ___Wheezing
Gastrointestinal: ___Frequent Bowel Movements ____Vomiting
Genitourinary: ____Abnormal Appearance
Neuromuscular: ____Seizures ____uncoordinated movements ____gait
Musculoskeletal: ____Fractures ____Deformity

Form Complete:______(staff initials)

WELL CHILD 2 YEARS Today's Date:________________

Patient Name:________________________________ Date of Birth:_________________

Weight:_______ Height:_______ Pulse:_______ Resp:_______ Temp:_______ Head Circum:_______

FOR OFFICE USE ONLY

PHYSICAL EXAM:	Normal	Abnormal	Comments
Appearance	_______	_______	______________________________
Head/fontanels	_______	_______	______________________________
Skin/nodes	_______	_______	______________________________
Eyes	_______	_______	______________________________
Symmetric Corneal light reflex	_______	_______	______________________________
Conjugate gaze bilaterally	_______	_______	______________________________
Red Reflex present bilaterally	_______	_______	______________________________
Ears	_______	_______	______________________________
Nose	_______	_______	______________________________
Mouth/Throat	_______	_______	______________________________
Teeth	_______	_______	______________________________
Neck	_______	_______	______________________________
Chest/breasts	_______	_______	______________________________
Heart/Pulses	_______	_______	______________________________
Lungs	_______	_______	______________________________
Abdomen	_______	_______	______________________________
Genitalia/anus	_______	_______	______________________________
Spine/Hips	_______	_______	______________________________
Extremities	_______	_______	______________________________
Muscle Tone	_______	_______	______________________________
DTRs	_______	_______	______________________________

ASSESSMENT: **1.** Well Child 2 Years Old__________________________ **2.**________________________________

3. ________________________________ **4.**________________________________

PLAN:

Immunizations: **Required:** ___Hep A # 1 ___PPD ___Hiberix (Hib+Tetanus Toxoid)

Catch up vaccinations: ___Hep B # 3 ___MMR # 1 ___Prevnar # 4 ___Varicella

___Parent declines (List)____

Lab Work Required for Medicaid: ___Lead ___Hct/Hgb Parent declines test: ___Lead ___Hct/Hgb

___Other labs:____________________________________

___ Hep C (if 12 months old or older and born to HCV infected woman)_________________________

Referral made to : ____

Dental: Parent advised to make Preventive Dental Appointment: ______

Health Education Handout Given to Parent/Guardian _______

EPDST Questionnaires/screens: ___TB questionnaire ___Lead questionnaire ___Autism Screen (catch up) **PEDS: ☐Pass ☐Fail**

_______RTC 6 months for 30 month exam RTC __________weeks/months/prn