VACCINES: P C

WELL CHILD 2 Yr 6 months (30 months) Today's Date:_____

Patient Name:_____ Date of Birth:_____

FAMILY HEALTH CENTER OF MISSION

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 Yr 6 months (30 months) Today's Date:_____

Patient Name:_____ Date of Birth:_____

Weight:_____ Height:_____ Temp:_____

FAMILY HEALTH CENTER OF MISSION

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

Catch up vaccinations: ___Hep B # 3 ___MMR # 1 ___Prevnar # 4 ___Varicella ___Hiberix (Hib)

___Parent declines (List)_____

Lab Work for Medicaid: Catch up if not done at 2 yr visit ___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: ____**Lead questionnaire given** ____**TB questionnaire given** ____Autism Screen **(Catch up)**

RTC in: _____months/prn _____yr/prn