WELL CHILD – 2 YEARS	Name: ☐ Female ☐ Male
Visit Date: ___/____/____	DOB: ____/____/____ Age: __________

Language: ☐ English Other: ☐ Interpreter used – Name:

T:	P:	RR:	HC:	Height: in.	Weight: lb.	BMI %:	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies:	**Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ no bottle ☐ low fat milk **WIC:** ☐ Yes ☐ No

Foods:

Appetite: **TB risk:** ☐ No ☐ Yes

Elimination:

Sleep:

Illness:

Childcare:

PARENTAL CONCERNS

GROWTH /DEVELOPMENT – Screen: ☐ Autism ☐ Developmental

☐ Kicks / throws ball	☐ Imitates adults	☐ Undresses self
☐ Handles spoon well	☐ Stacks 5 blocks	☐ 20 + words
☐ Shows affection	☐ Opens door	☐ 2 word phrases

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet	☐ no bottle ☐ regular meals with healthy snacks ☐ appropriate weight ☐ physical activity
Safety	☐ childproofing ☐ household safety ☐ water safety ☐ toddler car seat ☐ street dangers ☐ sun screen
Guidance	☐ start toilet training ☐ language development ☐ transition to bed ☐ peer play ☐ dental care ☐ discipline ☐ family dynamics ☐ parental time out

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Heart**	☐ regular rhythm ☐ no murmur
		Femoral pulses	☐ normal bilaterally
Head	☐ symmetrical	**Abdomen**	☐ soft, no masses ☐ liver & spleen normal
Eyes	☐ red reflex present R L ☐ no strabismus	**Genitalia**	☐ grossly normal
	☐ vision grossly normal	*male:*	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal	**Spine**	☐ normal, no sacral dimple
	☐ hearing grossly normal	**Extremities**	☐ no deformities, full ROM
Nose/mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction, no clicks
Teeth	☐ dentition WNL ☐ no cavities evident	**Skin**	☐ clear, no significant lesions
Neck	☐ supple / no masses	**Neurologic**	☐ normal tone ☐ normal DTR's
Lungs	☐ clear to auscultation bilaterally		

Comments:

ASSESSMENT:	**PLAN:**

ORDERS: ☐ Vaccine reactions, risks and follow-up explained /VIS sheets given ☐ Immunization registry entry

Immunizations- ☐ Influenza *(yearly)*

Fluoride - ☐ Rx. 0.25 mg qd ☐ Fluoride varnish

Labs: ☐ Hct. ☐ Lead blood test Other:

REFERRAL: ☐ WIC Other: ____ ☐ PM 160 completed

Next appointment: ☐ 1 year Other: ____________________________ **Provider Signature:** ___________________________