2 Year Well Exam

meridianhealth
A WellCare Company

Date____________________ Patient #____________________

Name____________________ Date of Birth____________________

Address____

____

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver

☐ Others (including siblings)____________________

____

May release information to (parent, guardian, other family - list):

____

____

Parental concerns: ____________________

____

Changes in child's health since last visit:____________________

____

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

- ☐ Take time for self and with partner. Participate in parent learning/support groups
- ☐ Family physical activities
- ☐ Help children resolve conflicts, express emotions

BEHAVIOR:

- ☐ Praise good behavior! Set consistent limits. Brief timeouts
- ☐ Play groups and socialization, should not expect to share toys
- ☐ Hug/talk/read/play together. Ask questions
- ☐ Support bilingual language usage
- ☐ Discourage almost all "screen time." If any, watch together and talk about what you see
- ☐ Toilet training: start only when child is ready. Patience. Use the same routine each day
- ☐ Expect curiosity about genitals
- ☐ Offer choices between 2 acceptable options

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Offer variety of foods, let child decide. Avoid struggles
- ☐ Structure 3 nutritious meals and 2 snacks per day
- ☐ Daily sit-down meals with family
- ☐ Brush teeth twice daily with small amount of fluoride toothpaste
- ☐ Dental home

SAFETY:

- ☐ **Constant supervision**. Keep away from lawn mowers, overheated garage doors, driveways, streets, etc
- ☐ Review car restraints. Model safe car behaviors
- ☐ Climbing precautions
- ☐ Is home fire safe? Fire/smoke, CO detectors
- ☐ Childproof home - hot liquids, matches, lighters, guns
- ☐ Water safety near tubs, pools, buckets
- ☐ If smoking in home: discuss quitting, limiting exposure

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care: ____________________

FAMILY RISK FACTORS

Changes in family since last visit:____________________

____

STRESS:

How much stress are you and your family under now?

☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?

☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other____________________

How stressful is caring for your child?

☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless?

☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?

☐ No ☐ Sometimes ☐ **Often**

GENERAL HEALTH

Nutrition/Dental

YES	NO	
☐	☐	Bottle or pacifier? _______times/day
☐	☐	Cow's milk ________oz/day
☐	☐	Juice ________oz/day
☐	☐	Eats all food groups daily, including fruits & veggies?
☐	☐	**Daily oral health care**
☐	☐	**Has had dental visit**

Elimination: ☐ Stooling: soft, easy to pass BMs________

Sleep:_____hours through the night

YES	NO	
☐	☐	Problems? Night feedings?____________________
☐	☐	Bottle to bed?

DEVELOPMENT (Screen or refer if concerns or "No" response on milestones in **bold type**; recommend autism screening; recommend developmental screening if no 30 month visit)

YES	NO	
☐	☐	**Plays along side other children**
☐	☐	**Pretend play such as feeding a doll***
☐	☐	**Says 50 words or more***
☐	☐	**Puts 2 words together, such as "more juice" (not just repeating)**
☐	☐	**Knows some body parts**
☐	☐	**Points to picture** **(*autism risk)**
☐	☐	**Stacks 4-5 blocks**
☐	☐	**Walks up stairs one step at a time, runs, kicks ball**

Family concerns about behavior, speech, learning, social or motor skills:

____

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MEDICAL HISTORY

Name____________________ Date of Birth____________________

Allergies____________________ Medications ____________________

Major medical illnesses/special healthcare needs ____________________

Hospitalizations/Surgeries ____________________

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:______R:______T:______BP:______ /______

Weight ______ (______%) Height ______(______%) BMI ______(______%)

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	
☐	☐	☐	☐	Behavior/interaction with family	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Teeth	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	
☐	☐	☐	☐	Autism screening (M-CHAT, other)	

Results reviewed (outside info, lab, etc.)____________________

Impression____________________

____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent ☐ UTD ☐ Missed previous well visit, being caught up

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused____________________

Lab (if indicated) ____________________

☐ **Fluoride varnish given**

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated)____________________

Handouts____________________

Return appointment____________________

Signature____________________ Date____________________