2 ½ Year Check Up - Parent's Page

Name:	Brought in by:	Date:
Allergies:	Medicines: Taking vitamin D?, fluoride?	Phone number:

What concerns do you want to talk about today?

____

Any illnesses, accidents, ER visits, visits to other doctors since last visit?

____

Did your child have any trouble with last visit's vaccines?___________________________

How does your child sleep?____

How many servings of vegetables does your child eat in a day? ____ How many of milk products?____

What activities does your child enjoy?

____

How is toilet training going? ____

How do you help your child learn how to behave? _______________________________

It this hard? ________Do you and other caregivers agree about how to discipline your child? ________

Child's safety and welfare:

How much TV and other screen time does your child have in a typical day? ____________

Does your child enjoy books? ______ How often do you read together? _______________

Is it easy to put your child into his or her car seat?	yes	no	sometimes
Are you brushing your child's teeth every day?	yes	no	sometimes
Have you done a toddler safety check on your home?	yes	no	sometimes

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Names at least one color	0	1	2
Tries to get you to watch by saying "Look at me"	0	1	2
Says his or her first name when asked	0	1	2
Draws lines	0	1	2
Talks so other people can understand him or her most of the time	0	1	2
Washes and dries hands without help (even if you turn on the water)	0	1	2
Asks questions beginning with "why" or "how" - like "Why no cookie?"	0	1	2
Explains the reasons for things, like needing a sweater when it's cold	0	1	2
Compares things - using words like "bigger" or "shorter"	0	1	2
Answers questions like "What do you do when you are cold?" or "…when you are sleepy?"	0	1	2

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	◯	◯	◯	◯	◯

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	◯	◯	◯	◯	◯
When you say a word or wave your hand, will your child try to copy you?	◯	◯	◯	◯	◯
Does your child look at you when you call his or her name?	◯	◯	◯	◯	◯
Does your child look if you point to something across the room?	◯	◯	◯	◯	◯

How does your child usually show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child...	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to...	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

2 ½ Year Check Up - Doctor's Page

Name:_______________________________________Age: _________Date: _____________

Vaccines given today: □ Varicella □ MMR □ HIB □ Prevnar □ DTaP □ Influenza

□ other:____
□ See vaccine registry for vaccine administration details
□ Prior reaction and immunizations reviewed and explained, VIS given

Reminders:
□ Be sure LEAD & H/H done

Physical exam: (check if normal)

□ see EMR for vitals and growth charts

□ General appearance
□ Head
□ ENT
□ Heart
□ Genitalia
□ Neurological
□ Parent child interaction

□ Skin
□ Eyes
□ Lungs
□ Abdomen
□ Extremities
□ Milestones consistent with history
  □ eye contact observed
  □ pretend play observed
  □ follows indicative pointing w/ eyes on object
  □ initiates indicative pointing w/ eyes on face
  □ stacks blocks (#____)

□ Dental oral evaluation done (CPT: D01.45 ICD10: 99420)
□ Dental varnish applied (CPT: D12.06 ICD10: 99188)

Assessment:
□ well baby - no concerns
□ Score on developmental screening (CPT: Z13.4 and ICD10: 96110)

Plan:
□ follow up 3 years for WCC □ scheduled
vaccines expected:____
□ flu booster in 1 mos □ scheduled

Topics discussed:
□ oral health
□ development

□ 30 month handouts reviewed and given.

Signature: ___________________________