Two 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?

_____

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
Are you feeling confident in caring for your toddler?	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 5 body parts - like nose, hand, or tummy	0	1	2
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2
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

Are there things you need help with?

How confident are you filling out medical forms by yourself? Extremely Somewhat Not at all

How is life at home?

Is your family working well together?	yes	no	maybe
Is there a lot of stress in your family?	yes	no	sometimes
Is there smoking or vaping in your home?	yes	no	sometimes
Is anyone drunk or high around your child?	yes	no	sometimes
Has anyone hurt, hit, or threatened you or your child?	yes	no	maybe
Are you treated with respect by your partner and others at home?	yes	no	sometimes

How are you doing?

In the past month, if you needed someone to listen or to help you, was someone there for you?

Yes, as much as I want Yes, quite a bit Yes, some Yes, a little No not at all

Are you concerned about your health?	yes	no	sometimes
Would you like to become pregnant in the next year?	yes	no	maybe
Do you need help getting birth control or other health care?	yes	no	maybe

Over the past two weeks:

Have you felt down, depressed or hopeless?

not at all several days more than half the days nearly every day

Have you had little interest or pleasure in doing things?

not at all several days more than half the days nearly every day

Have you been troubled by anxiety, worry or nervousness?

not at all several days more than half the days nearly every day

Over the past year:

Have you used alcohol or drugs more than you meant to?	yes	no	maybe
Did you want or need to cut down on your drinking or drug use?	yes	no	maybe

Over the last year, have you had what you needed: (please circle)

Food	we always have enough to eat	we worry we will run out	we run out some months	we often don't have enough
Housing	we have a secure home with utilities without problems	we worry we will lose our home or utilities	There are serious problems with our home	we don't have a steady home
Transportation	we can always get where we need to go	we usually can get where we need to go	we often can't get where we need to go	we can't get to important things
Phone	we always have a reliable phone	we usually have a a phone	We can only text when on wifi	we have no phone or text
Health insurance	We have reliable health insurance	We can't afford our out-of-pocket costs	We worry we will lose our insurance	Some of us have no insurance
Child care	We don't need childcare	We have reliable childcare that we can afford	We can't find reliable childcare	We can't afford childcare

Two 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:
□ LEAD & H/H due

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

Plan:
□ follow up 30 months for WCC □ scheduled
vaccines expected:_____
□ flu booster in 1 mos □ scheduled
□ LEAD & H/H done

Topics discussed:
□ oral health
□ social determinates of health needs

24 month handouts given after reviewing with patient:

Signature: _____