Iowa Child Health and Development Record

2 year Well Exam

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:_____

GENERAL HEALTH:

Nutrition/Dental:

YES	NO	
❑	❑	Bottle or pacifier?____times/day
❑	❑	Cow's milk____oz/day
❑	❑	Juice ____oz/day
❑	❑	Daily eats all food groups, incl. 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-mo. 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**
❑	❑	**Stacks 4-5 blocks**
❑	❑	**Walks up stairs one step at a time, runs, kicks ball**

***(autism risk)**

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

MEDICAL HISTORY:

Medications:_____ Allergies:_____

Major medical illnesses:_____

Hospitalizations_____

Surgeries:_____

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare: _____

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? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ 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**

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.
- ❑ Playgroups and socialization, but 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 same routine each day.
- ❑ Expect curiosity about genitals.
- ❑ Offer choices between 2 acceptable options

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Offer variety 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 Fl toothpaste.
- ❑ Dental home

SAFETY:

- ❑ **Constant** supervision. Keep away from lawn mowers, overhead 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

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ BP____/_____Weight_____(_____%) Height_____(_____%)

BMI_____ (_____%) Head Circumference _____ (_____ %)

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_____

❑ ❑ Neurologic _____

❑ ❑ Developmental Screening (ASQ, other)_____ ❑ ❑ Autism Screening (M-CHAT, other)_____

Results reviewed: (outside info, lab, etc.)_____

Impression:_____

PLAN OF CARE (see Anticipatory Guidance)

❑ **Fluoride varnish given** (if high risk, such as all Title 19 patients)

Immunizations: ❑ UTD - not indicated ❑ Missed previous well visit; being caught up

❑ Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: ❑ No ❑ Yes_____

See current guidelines www. immunize.org/aap

LAB: ❑ Lead ❑ Hb or Hct: Assess risk ❑ TB: Assess risk ❑ Lipids: Assess risk ❑ other if indicated_____

Referral: (if indicated)_____

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229

For referral of children ***birth to age 3*** with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts:_____

Return appointment:_____

Signature _____ Date _____