

**SOUTHLAKE PEDIATRICS
HEALTH SUPERVISION VISIT 24 MONTHS**

Name: _____ DOB: _____

Date of Visit _____ Age _____

Parental Language Barrier: N Y _____

PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

No Concerns

PAST MEDICAL HISTORY

Allergies _____ Immunization Reactions _____

Other _____

PRESENT HISTORY

Meds: _____

Diet _____

Low-fat Milk _____

Food Groups _____

Toilet Learning _____

Sleep/Naps _____

Dental _____

SOCIAL

Preschool/Mother's Day Out/Day Care _____

Behavior/Discipline _____

Daily screen time _____

FAMILY

Smoke Exposure Yes No _____

Other _____

Information completed by: _____

Relationship to child: _____

ASQ FORM:

REVIEWED

RESULTS: N AB

REFERRED _____

M-CHAT FORM:

REVIEWED

RESULTS: N AB

PHYSICAL EXAMINATION

Length _____ % _____ Weight _____ % _____

BMI _____ BMI% _____ HC _____ Temp _____

N AB COMMENTS

Gen. Appearance _____

Skin _____

Head/Fontanel _____

Eyes/RR/Strabismus _____

Ears/Nose/Oropharynx _____

Neck/Nodes _____

Chest/Lungs _____

Cardiovascular/Pulses _____

Abdomen _____

Genitalia _____

Musculoskeletal/Hips _____

Neuro/Reflexes _____

Hearing _____

Vision _____

ANTICIPATORY GUIDANCE

Diet

- Low Fat Milk
- Balanced meals TID
- Avoid "struggle" over food
- Limit juice/Kool-aid/Soda

- Drowning/water safety
- No unsupervised play
- Burn prevention: Heat & Electrical

Development

- Play with child
- Encourage learning/Books
- TV Habits

Medical Education

- No Smoking
- Acetaminophen/Motrin Dose
- Telephone

Injury Prevention

- Toddler Car Seat

Dental Education

- No bottle
- Brush Teeth

LABS

- Hgb/Hct _____ Lead Risk Factors Yes No
- Tb Skin Test _____ Risk Factors Yes No

IMMUNIZATIONS: Varivax Hep A

Other _____

ASSESSMENT/RECOMMENDATIONS

- Healthy Toddler
- Dental Referral

Return for 3 year checkup

_____, M.D.

SICK VISIT – Mod 25

CC: _____

HPI: _____

MDM: _____

>50% of _____ min visit spent counseling