California Pediatrics
Come grow with us

24 Month Well Exam

Name
Room
Notes

Weight	T	HCT				
Length	HR	MCHAT				
OFC	RR					
	O2					

Nutrition

What foods does your child eat?	Veggies	Fruit	Protein		
Does your child eat 3 meals per day?	Yes	No			
What type of milk does your child drink?	2% or 1%	Whole	Breast	Formula	
How much milk does your child drink?	12-16oz	<12oz	>16oz		

Dental

Do you brush your child's teeth?	Yes	No			
Does your child see a dentist twice per year?	Yes	No			
Does your child drink from a bottle?	No	Yes			

Sleep

Does your child sleep through the night?	Yes	No			
Does your child take naps?	Yes	No			
Does your child snore?	No	Yes	Pauses?	No	Yes

Development

Do you feel that your child sees well?	Yes	No			
Do you feel that your child hears well?	Yes	No			
Does your child put 2 words together ('Let's go')?	Yes	No			
Can your child turn the pages of a book?	Yes	No			
Can your child run, jump, kick and throw?	Yes	No			
Does your child play alongside other children?	Yes	No			
Is your child interested in potty training?	Yes	No			
Do you read to your child?	Yes	No			

Safety

Have you babyproofed your home?	Yes	No			
Do you have the number to Poison Control?	Yes	No			
Does your child use a carseat?	Yes	No			
Any smokers at home?	No	Yes			

Risk Assessment

Has your child traveled outside of the U.S. in the last 6 months?	No	Yes			
Exposure to anyone with a positive TB skin test?	No	Yes			
Does your child live in or visit a home built before 1978?	No	Yes			
Does your child live in or visit a home with chipping paint?	No	Yes			

Followup D/W/M
Reason:

□EHR