**WILD PLUM CENTER**



**CHILD HEALTH EXAM FORM**

**BIRTH-2 YEARS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **WEIGHT** | **HEIGHT** | **HEAD CIRC(up to 24 mo)** | **DATE** |
| **DOB** | **AGE** **M F** | **WEIGHT %** | **HEIGHT %** | **HEAD CIRC %** |  |
| **HISTORY PHYSICAL EXAMINATION** |

* LUNGS
* ABDOMEN
* BACK
* SKIN
* GENITALIA
* OTHER
* = NL
* GENERAL APPEARANCE EXTREMITIES/HIPS
* HEAD/FONTANELLE LUNGS
* EARS ABDOMEN
* NOSE BACK
* MOUTH AND THROAT SKIN
* HEART TEETH

**ABNORMAL FINDINGS AND COMMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* **Child has dental home**
* **Child has special needs**
* **Allergies\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Concerns and Questions None**

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**Changes since last visit None**

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**\*(if has allergies, please complete allergy form)**

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| **REQUIRED SCREENINGS** |

* **BLOOD LEAD LEVEL (AGES 12 & 24 MONTHS)…….. VALUE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hgb/Hct (AGE 9-12 MONTHS)…………VALUE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **HEARING…………NORMAL\_\_\_\_\_\_\_ABNORMAL\_\_\_\_\_\_\_\_**
* **VISION…………….NORMAL\_\_\_\_\_\_\_ABNORMAL\_\_\_\_\_\_\_\_**
* **DENTAL**
* **Dental Hygiene Discussed**
* **Caries, White Spots, Staining**
* **Gum Observation**

|  |
| --- |
| **DEVELOPMENTAL ANTICIPATORY GUIDANCE (See back of form)** |
| * **SOCIAL EMOTIONAL**
* **COMMUNICATIVE**
* **COGNITIVE**
* **PHYSICAL DEVELOPMENT**
 | * **COMPLETED**
* **COMMENTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PLAN ASSESSMENT** |
| * **IMMUNIZATIONS**
* **LAB WORK**
* **DENTAL**
* **REFERRALS TO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | * **WELL CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **SIGNATURE OF PROVIDER:** |

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