### History

- **BF** Previsit Questionnaire reviewed
- **BF** Child has a dental home
- **BF** Child has special health care needs
- **BF** Concerns/questions raised by ____________________________
  - None
  - Addressed (see other side)
- **BF** Follow-up on previous concerns
  - None
  - Addressed (see other side)
- **BF** Medication Record reviewed and updated

### Social/Family History

- **BF** Family situation
  - Single Parent
- **BF** Parents working outside home:
  - Mother
  - Father

- Child care:
  - Yes
  - No
  - Type ______________

- Changes since last visit __________

- **BF** Tobacco Exposure

### Review of Systems

- **= NL**

  - Date of last visit __________
  - Changes since last visit __________

  - Nutrition, balanced, eats with family
    - Source of water __________ Vitamins/Fluoride __________

  - Elimination:
    - In process __________ NL __________
    - Toilet Training: ____________________________
      - Yes

  - Sleep:
    - NL __________

  - Behavior/Temperament:
    - NL __________

  - Physical activity __________ Playtime (60 min/day) __________

  - Screen time (<2 hrs/day) __________

### Anticipatory Guidance

- Family routines
  - Family meals
  - Family activities

- Language promotion and communication
  - Limit TV
  - Daily reading

- Social development
  - Supervised play with other children

- Preschool considerations
  - Group activities/ preschool (if possible)
  - Toilet training

- Safety
  - Car safety seat
  - Water
  - Appropriate supervision
  - Sun exposure
  - Smoke detectors
  - Outdoor safety
  - Playground
  - Dogs

---

**Notes**

- Bright Futures Priority Item

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### Physical Examination

- **= Reviewed w/Findings** OR **NL = Reviewed/Normal**

  - General appearance __________
  - Skin __________
  - Head __________

  - **BF** EYES (red reflex, cover/uncover test) __________

  - Ears __________
  - Nose __________
  - Mouth and throat __________
  - Teeth (caries, dental injuries) __________
  - Neck __________
  - Lungs __________
  - Heart __________
  - Abdomen __________
  - Genitalia __________
    - Male/Testes down, __________
    - Female __________

  - **BF** Neurologic (coordination, language, socialization) __________

  - Extremities/hips __________
  - Musculoskeletal __________
  - Hygiene __________
  - Back __________

- **BF** Comments ____________________________

---

(see other side for plan, immunizations and follow-up)

- **BF** Well Child
## 2 ½ Years

### WELL CHILD VISIT

<table>
<thead>
<tr>
<th>NAME</th>
<th>Medical Record Number</th>
<th>DOB Actual age (months): O 29 O 30 O 31 O 32</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Medications</th>
<th></th>
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<tbody>
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<td></td>
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</tbody>
</table>

### Plan

**BF** Patient is up to date, based on CDC/ACIP immunization schedule.  
If no, immunizations given today.  
Immmunization status:

- Immunization plan/comments

**Oral Health**

- Oral health risk assessment
  - Completed
  - Low
  - Mod
  - High

- Has a dental home
  - Yes
  - No

- Dental fluoride varnish applied
  - Yes
  - No

- Dental Visit in Past Year
  - Yes
  - No

- Well water testing
  - Yes
  - No

### Laboratory/Screening results

#### Hearing screen

- Previously done
- Date completed

**PPD / Lead** / **Anemia**

- PPD done (if exposure risk) / date done
- PPD result if done
  - Neg
  - Pos

- PPD plan/comments

**Lead** drawn in office

**Lead test ordered / date done**

**Lead range**

- <10
- 10-14
- 15-19
- >19

**Lead plan/comments**

- Hgb/Hct ordered / date done
- Hgb/Hct result: Hgb
  - Hct
  - Referral at 6 months if still anemic

**Hgb/Hct plan/comments**

**FPD / PPD / Lead** / **Anemia**

- FPD done
- Date done
- PPD result if done
  - Neg
  - Pos

- FPD plan/comments

**Lead** drawn in office

**Lead test ordered / date done**

**Lead range**

- <10
- 10-14
- 15-19
- >19

**Lead plan/comments**

**Hgb/Hct ordered / date done**

**Hgb/Hct result:**

- Hgb
- Hct
  - Referral at 6 months if still anemic

**Hgb/Hct plan/comments**

### MaineCare Member Support Requested

- Transportation to appointments
- Find dentist
- Find other provider
- Make doctor’s appointment
- **Public Health Nurse referral**
- Family aware

### BF Referral

### BF Follow-up/Next Visit

### Narrative Notes:

- Find dentist
- Find other provider
- Make doctor’s appointment
- Public Health Nurse referral
- Family aware

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**STATE OF MAINE**

**Department of Health and Human Services**

**EXAMINER’S SIGNATURE**

**DATE**