Clear Form

MINNESOTA Child and Teen Checkups

2-Month Well Visit

Patient information

Patient's name: _____

Medical record number: _____

Date of visit: _____ Date of birth: _____

Age: ____ months and ____ weeks Gender: _____

Accompanied by: _____

Health history

Parent or caregiver concerns today:

◯ New patient: Comprehensive prenatal, health and family history reviewed

◯ Returning patient: Interim history reviewed

Newborn blood spot, hearing, CHD results documented?

◯ Yes ◯ No

Further follow-up needed? ◯ No ◯ Yes: _____

Pertinent prenatal or newborn history, family history or changes:

Allergies: _____

Medications (including vitamins, supplements or OTC meds):

Social history

Patient lives with: _____

Primary caregiver(s): _____

Child care: _____

Housing stability, food security or concerns:

Family changes or stressors, exposure to family or community violence:

Social and community supports:

Is patient in foster care or out-of-home placement?

◯ No ◯ Yes (follow AAP guidelines: Primary Care Tools for foster care)

Daily activities

Nutrition (breastfeeding duration, iron-fortified formula ounces per feeding, frequency, concerns):

Sleep (patterns, hours of sleep per 24 hours, sleep position and environment):

Elimination (voiding and stooling frequency, concerns):

Activity (tummy time, reading, face-to-face time, other):

Measurements

Head circumference: ____ cm (or ____ in), percentile for age: ____ %

Weight: ____ kg (or ____ lbs. and ____ oz.), percentile for age: ____ %

Length: ____ cm (or ____ in), percentile for age: ____ %

Weight for length percentile for age: ____ %

Developmental and social-emotional health

Surveillance (required)

Recent milestones (refer to CDC or Bright Futures milestones resources):

Parent or caregiver concerns about infant development or behavior?

◯ No ◯ Yes: _____

Observations of parent-child interaction (strengths, concerns):

Developmental screening (if done)

Instrument: ☐ ASQ-3 ☐ PEDS

☐ Other recommended instrument: _____

Result: ◯ Pass ◯ Monitoring zone ◯ Refer

Social-emotional screening (if done)

Instrument: ☐ ASQ: SE-2

Result: ◯ Pass ◯ Monitoring zone ◯ Refer

Postpartum depression screening (recommended)

Instrument: ☐ Edinburgh ☐ PHQ-9 ☐ Beck Depression Inventory

☐ Results reviewed; follow-up plan discussed as appropriate

Screening comments:

Risk assessment

Sleeps on back in safe sleep environment

◯ Yes ◯ No: _____

Car seat with 5-point harness, facing backwards in back seat

◯ Yes ◯ No: _____

Vision concern or risk

◯ No ◯ Yes: _____

Hearing concern or risk

◯ No ◯ Yes: _____

Lead exposure risk (elevated maternal prenatal lead level?)

◯ No ◯ Yes: _____

Tuberculosis risk (may use MDH form)

◯ No ◯ Yes: _____

Tobacco exposure

◯ No ◯ Yes: _____

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Review of systems

Constitutional	◯ Neg	◯ Pos		Neuromuscular	◯ Neg	◯ Pos	
HEENT	◯ Neg	◯ Pos		Skin	◯ Neg	◯ Pos	
Cardiovascular	◯ Neg	◯ Pos		Hematologic/lymph	◯ Neg	◯ Pos	
Respiratory	◯ Neg	◯ Pos		Endocrine/immune/allergic	◯ Neg	◯ Pos	
GI/GU	◯ Neg	◯ Pos		Psychosocial/behavioral	◯ Neg	◯ Pos	

Physical exam

◯ Normal ◯ Abnormal **General appearance** _____

◯ Normal ◯ Abnormal **Skin:** birthmarks, rash, lesions, scars _____

◯ Normal ◯ Abnormal **Nodes:** cervical, axillary, inguinal, other _____

◯ Normal ◯ Abnormal **Head:** fontanelles, shape and size, scalp, hair _____

◯ Normal ◯ Abnormal **Eyes:** lids, sclera, PERRLA, RR++, corneal light reflex _____

◯ Normal ◯ Abnormal **Ears:** position, pinna, canals, TMs _____

◯ Normal ◯ Abnormal **Nose:** nare symmetry, patency _____

◯ Normal ◯ Abnormal **Mouth:** tongue, frenulum, gums, mucosa, palate; suck and root reflexes _____

◯ Normal ◯ Abnormal **Neck:** torticollis, head control, ROM _____

◯ Normal ◯ Abnormal **Chest:** shape, symmetry, clavicles, lung sounds, respiratory rate _____

◯ Normal ◯ Abnormal **CV:** rate, rhythm, S1/S2, murmur, femoral pulses _____

◯ Normal ◯ Abnormal **Abd:** contour, umbilicus, liver, spleen, masses, bowel sounds, anus _____

◯ Normal ◯ Abnormal **GU:** labial-vaginal mucosa or penis, testes ↓ ↓, hernia _____

◯ Normal ◯ Abnormal **MS:** ROM, symmetry, hip stability, feet, spine _____

◯ Normal ◯ Abnormal **Neuro:** tone, jitteriness, DTRs; reflexes: Moro, tonic neck, grasp, Babinski, step _____

Assessment

☐ Well child or C&TC visit completed ☐ Refer to separate documentation notes

☐ Additional findings or diagnoses (specify):

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Plan

Immunization review (required)

☐ Up to date (no vaccines due today) ☐ High risk: refer to schedule

Due for: ☐ Hep B ☐ Rotavirus ☐ DTaP ☐ HIB ☐ PCV13 ☐ IPV ☐ Other: _____

Given: ☐ Hep B ☐ Rotavirus ☐ DTaP ☐ HIB ☐ PCV13 ☐ IPV ☐ Other: _____

Reason not given, if due: _____

Laboratory tests

☐ Lead (if prenatally exposed or other risk)

☐ Newborn screening follow-up: _____

☐ Other: _____

Anticipatory guidance (potential resources are hyperlinked)

Topics discussed, based on patient and family needs:

☐ Simple, consistent routines (feeding, sleeping, resting when baby sleeps)

☐ Supporting baby's development: holding and bonding, responding to crying, face-to-face time, reading; more supervised tummy time and floor time to practice reaching and rolling

☐ Infant temperament, parent-child and sibling relationships, family well-being, support systems

☐ Calming a fussy baby; step away if needed; never shake a baby

☐ Infant feeding; only breastmilk or iron-fortified formula at this time

☐ Tips to help baby sleep safely

☐ Child passenger safety; look before you lock (avoiding car heatstroke)

☐ Preventing injury from falls, burns or other accidents; never leave alone in tub or on high surfaces

☐ Avoid any smoke exposure

☐ Equipment safety (cribs, swings, walkers, Johnny Jump Up, etc.)

☐ Oral health: wash mouth with washcloth and water daily

☐ Protect from sun exposure

☐ Smoke alarms on every level of home, carbon monoxide detectors in sleep areas of home

☐ Postpartum wellness and depression (resource: maternal well-being plan)

☐ Other anticipatory guidance: _____

Referrals

HIPAA Compliant Referral Condition Code (**required** for complete C&TC)

◯ Patient needs further evaluation or follow-up (write in referred-to provider and reason for referral for ST, S2, *or* AV)

◯ **ST:** Referral to follow-up here or to another provider for newly identified condition:

_____

◯ **S2:** Continue follow-up with provider for previously referred condition:

_____

◯ **AV:** Parent or guardian declines referral for:

_____

◯ **NU:** No condition requires follow-up or referral

Additional recommendations

☐ Medications, supplements, treatments:

☐ WIC (enrolled or encouraged to enroll)

☐ Help for housing, food access (SNAP or other resources) or other family concerns:

☐ Early Head Start or quality child care options (Parent Aware)

☐ Next well visit at 4 months, or sooner if needed: _____

☐ Quitting tobacco encouragement, resource provided

☐ Other community referrals, resources, education (such as ECFE):

☐ Other recommendations (follow-up, actions to take at home, etc.):

PROVIDER SIGNATURE, CREDENTIALS			DATE
CLINIC NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE