La Loma
24 Month Well Child **Date: _____**

Name:_____ DOB:_____ Age:_____

Medications:		
Is your child on any medications?	YES ☐	NO ☐
If Yes, Please List:		
Allergies:		
Does your child have any allergies to medications? If so, please list	YES ☐	NO ☐
Sensory:		
Vision:		
Does your child appear to be able to see well?	YES ☐	NO ☐
Hearing/Speech:		
Does your child appear to be able to hear?	YES ☐	NO ☐
Does your child speak at least 20 words understandable by others?	YES ☐	NO ☐
Development:		
Does your child use two-word phrases?	YES ☐	NO ☐
Can your child jump?	YES ☐	NO ☐
Does your child use pronouns such as, I, You, or Me?	YES ☐	NO ☐
Can your child kick a ball?	YES ☐	NO ☐
Can your child follow two-step commands? (e.g. Pick up the paper and give it to me?)	YES ☐	NO ☐
Can your child stack 5 or 6 blocks?	YES ☐	NO ☐
Does your child ask frequent questions?	YES ☐	NO ☐
Can your child use a spoon?	YES ☐	NO ☐
Can your child remove his/her clothes?	YES ☐	NO ☐
Can your child point to a body part?	YES ☐	NO ☐
Nutrition:		
Does your child overall eat well (eat a generally diverse diet)?	YES ☐	NO ☐
Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron	YES ☐	NO ☐

Do you have any concerns regarding your child? ☐ NO ☐ YES (Explain Below)

Signed_____ Printed Name_____
Relationship to Patient? _____ Date_____

La Loma Internal Medicine and Pediatrics

Child COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child. Explain all yes answers at the end of the last page.

Name: _____ DOB: _____

GENERAL:

When was your child's last Well Child Check?	Date	
Has your child had a recent UNEXPLAINED loss of weight?	YES ☐	NO ☐
Does your child have a fever?	YES ☐	NO ☐
Does your child have excessive fatigue?	YES ☐	NO ☐
Does your child have an acceptable appetite?	YES ☐	NO ☐

EARS, EYES, NOSE, THROAT:

Does your child have any drainage from eyes?	YES ☐	NO ☐
Does your child have any redness or irritation in eyes?	YES ☐	NO ☐
Does your child complain of itchy watery eyes?	YES ☐	NO ☐
Does your child have Nasal Congestion?	YES ☐	NO ☐
Does your child have frequent runny noses?	YES ☐	NO ☐
Does your child suffer from frequent bloody noses? If so, how many per week?	YES ☐	NO ☐

PULMONARY/ LUNGS:

Is your child frequently short of breath? (If yes, AT REST or WITH ACTIVITY)	YES ☐	NO ☐
Does your child cough <u>most days?</u>	YES ☐	NO ☐
Does your child cough up blood?	YES ☐	NO ☐
Has your child had a continuous cough for longer than two to three months?	YES ☐	NO ☐
Does your child Wheeze?	YES ☐	NO ☐

CARDIOVASCULAR/HEART:

Does your child seem to have a racing heart?	YES ☐	NO ☐
Does your child's extremities swell?	YES ☐	NO ☐
Does your child have trouble breathing while lying flat?	YES ☐	NO ☐
Does your child sweat excessively during feedings?	YES ☐	NO ☐
Does your child turn blue around the mouth or have rapid breathing during feedings?	YES ☐	NO ☐

Name: _____ DOB: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:

Does your child complain OFTEN of stomach pains?	YES ☐	NO ☐
Does your child have frequent vomiting?	YES ☐	NO ☐
Does your child have frequent diarrhea?	YES ☐	NO ☐
Does your child have bright red blood in stools?	YES ☐	NO ☐
Does your child have black tarry stools?	YES ☐	NO ☐
Does your child have frequent constipation?	YES ☐	NO ☐
Does your child have difficulty swallowing?	YES ☐	NO ☐

GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:

Does your child have several wet diapers in a 24-hour period?	YES ☐	NO ☐
Does your child have any blood in urine?	YES ☐	NO ☐
Does your child urinate more frequently than normal?	YES ☐	NO ☐
Does your child have sores / lesions on genitals?	YES ☐	NO ☐

HEMATOLOGIC (BLOOD)

Does your child have problems with bleeding or a history of hemophilia? (Circle which one)	YES ☐	NO ☐
Does your child have a history of anemia?	YES ☐	NO ☐
Does your child have swollen glands that do not resolve?	YES ☐	NO ☐

ENDOCRINE (GLANDS)

Does your child have problems with excessive thirst?	YES ☐	NO ☐
Does your child have dry brittle hair and nails?	YES ☐	NO ☐

MUSCULOSKELETAL / SKIN

Does your child complain often of joint pain?	YES ☐	NO ☐
Does your child have joints that swell or get red? (Circle which one or both)	YES ☐	NO ☐
Does your child often have a rash?	YES ☐	NO ☐

NEUROPSYCHIATRIC (NERVES, BRAINS)

Does your child appear to move arms and legs normally?	YES ☐	NO ☐

Child's Name _____ Filled out by: _____

Date of Birth _____ Relationship to child _____

Today's date _____

Modified Checklist for Autism in Toddlers (M-CHAT)

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.		**YES**	**NO**
1.	Does your child enjoy being swung, bounced on your knee, etc.?	☐	☐
2.	Does your child take an interest in other children?	☐	☐
3.	Does your child like climbing on things, such as up stairs?	☐	☐
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	☐	☐
5.	Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	☐	☐
6.	Does your child ever use his/her index finger to point, to ask for something?	☐	☐
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	☐	☐
8.	Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them?	☐	☐
9.	Does your child ever bring objects over to you (parent) to show you something?	☐	☐
10.	Does your child look you in the eye for more than a second or two?	☐	☐
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	☐	☐
12.	Does your child smile in response to your face or your smile?	☐	☐
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	☐	☐
14.	Does your child respond to his/her name when you call?	☐	☐
15.	If you point at a toy across the room, does your child look at it?	☐	☐
16.	Does your child walk?	☐	☐
17.	Does your child look at things you are looking at?	☐	☐
18.	Does your child make unusual finger movements near his/her face?	☐	☐
19.	Does your child try to attract your attention to his/her own activity?	☐	☐
20.	Have you ever wondered if your child is deaf?	☐	☐
21.	Does your child understand what people say?	☐	☐
21.	Does your child sometimes stare at nothing or wander with no purpose?	☐	☐
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	☐	☐

http://www.dbpeds.org/media/mchat

🧸 Your Child's Checkup & What It Covers

Making the Most of Your Child's Annual Physical — With Clear Info About Billing

We want your child's yearly checkup to be helpful, healthy, and happy! Here's what's included—and what might come with extra costs—so there are no surprises.

🩺 What's Included in a Regular Checkup (Preventive Visit):

Your child's annual physical is all about keeping them growing strong! It includes:

- ✅ A full physical exam
- ✅ Tracking growth, development, and overall health
- ✅ Sports physical paperwork if needed
- ✅ Routine vaccines to keep your child protected
- ✅ Preventive lab orders (Lab benefit coverage is determined by your insurance company)

⚠️ What's *Not* Included — May Have Extra Charges:

Sometimes, other health concerns come up during the visit. If we treat or discuss things like:

- 🧠 Ongoing conditions (like ADHD, asthma, depression etc)
- 🤒 New symptoms (like a sore throat, rash, or injury etc)
- 💊 Medication changes or refills for chronic issues
- 💉 Tests for illness (like strep tests, X-rays, or extra lab work)
- 🗣️ Longer discussions about complex concerns

These are considered *separate* services by insurance and may come with a co-pay, deductible or other charges.

📋 Why Things Are Different Now:

In the past, we could sometimes include extra care in the checkup without extra billing. But, in an effort to follow current billing and insurance requirements, we now have to bill separately for non-preventive care even if it happens during the same visit.

💙 Our Promise to You:

We follow these rules to make sure everything is billed correctly and fairly. Our goal is to care for your child in one visit whenever possible—so you don't have to come back again and again.

If you ever have questions about your child's visit or the bill, our team is here to help. We want you to feel confident and informed every step of the way!