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Practice Questions

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1. A 15-month-old boy is brought to the office for a well-child visit. His mother reports that he does not yet speak any words and does not respond when she calls his name. He can pull to stand and cruise along furniture but does not walk independently. Physical examination shows normal growth parameters. He makes limited eye contact and does not wave bye-bye. The physician reviews standardized developmental screening results indicating delays in both language and social domains. Which of the following screening timelines and actions is most appropriate for this patient? Age Screening Type Action if Delay Identified Key Red Flags 9 months General developmental Refer to early intervention (Part C) No babbling, poor social engagement 18 months General + autism-specific Immediate referral to early intervention + audiology No single words, no pointing, no imitation 24 months Autism-specific Immediate referral for autism evaluation No two-word phrases, loss of skills 30 months General developmental Refer to early intervention if not improving Persistent language or motor delays

A. Perform autism-specific screening (M-CHAT) and refer based on results
B. Reassure the mother that late talking is common and follow up at 24 months
C. Immediate referral to early intervention without audiology evaluation
D. Immediate referral to early intervention and audiology evaluation

2. A 7-month-old girl is brought to the office for evaluation. Her parents report that she has not yet started babbling and rarely smiles at them. She can sit with support but cannot sit independently. She reaches for toys with a raking grasp. Birth history is unremarkable and she was born at 39 weeks' gestation. Physical examination shows normal growth parameters. She makes inconsistent eye contact and does not turn toward sounds. Hearing screening at birth was normal. Which of the following milestone patterns is most concerning and warrants urgent evaluation?

A. Absent babbling and poor social smile at 7 months
B. Sitting with support but not independently at 7 months of age
C. Using raking grasp rather than pincer grasp for reaching toys
D. Not yet walking independently or cruising along furniture

3. A 4-year-old boy with acute lymphoblastic leukemia in remission is brought to the office for a well-child visit. His mother reports that he missed multiple vaccinations during chemotherapy treatment, which ended 6 months ago. His current medications include daily mercaptopurine. Laboratory studies show absolute neutrophil count 1800/mm³ and absolute lymphocyte count 1200/mm³. According to his immunization record, he has not received MMR, varicella, or DTaP vaccines since age 12 months. His oncologist confirms he is no longer severely immunocompromised. Which of the following vaccination schedules is most appropriate? Vaccine Type Minimum Age Minimum Interval Contraindication in Immunocompromise MMR Live 12 months 28 days from other live vaccine Severe immunocompromise Varicella Live 12 months 28 days from other live vaccine Severe immunocompromise DTaP Inactivated 6 weeks 4 weeks between doses None IPV Inactivated 6 weeks 4 weeks between doses None

A. Administer MMR and varicella together today, then DTaP in 4 weeks
B. Administer MMR today, varicella in 2 weeks, and DTaP in 6 weeks
C. Administer DTaP today, then MMR and varicella together in 4 weeks
D. Administer DTaP and MMR today, then varicella vaccine in 2 weeks

4. A 9-month-old boy is brought to the office for evaluation of poor weight gain. His mother reports he has been irritable during feedings and often refuses to eat. Review of his growth chart shows serial measurements as follows: Age Weight Weight Percentile Length Length Percentile 2 months 5.8 kg 75th 58 cm 50th 4 months 6.9 kg 50th 63 cm 50th 6 months 7.2 kg 25th 66 cm 50th 9 months 7.5 kg 5th 69 cm 25th

A. Weight and length both declining proportionally from 50th to 25th percentile
B. Weight remaining consistently between 5th and 10th percentile across all visits
C. Length percentile declining from 50th to 25th while weight remains stable at 50th
D. Weight increasing from 5.8 kg to 7.5 kg with proportional length increase

5. A 16-year-old girl comes to the office for a routine health maintenance examination. Her mother accompanies her and remains in the room. The patient appears healthy and reports no concerns. After completing the physical examination, the physician asks the mother to step out to speak with the patient privately. Once alone, the patient reports that she has been sexually active with her boyfriend for 3 months and wants to start oral contraceptives. She says her mood has been 'okay' but admits to feeling 'stressed' about school. She denies suicidal thoughts, substance use, or concerns about her relationship. Which of the following is the most appropriate next step?

A. Order pregnancy test and sexually transmitted infection screening before prescribing contraception
B. Perform confidential screening for depression and risky behaviors, then discuss contraception
C. Inform the mother of the patient's request and obtain parental consent for contraception
D. Prescribe oral contraceptives and schedule follow-up in 3 months for monitoring

6. A 20-month-old girl is brought to the office because her parents are concerned about her development. She speaks only 5 single words and does not combine words. She can walk well and run, but she does not yet walk up stairs. She feeds herself with a spoon and drinks from a cup. She points to objects she wants and waves bye-bye. Physical examination shows normal growth parameters and no dysmorphic features. Which of the following is the most appropriate management at this time?

A. Perform autism-specific screening with M-CHAT and refer based on score
B. Refer directly to speech therapy without hearing evaluation at this time
C. Repeat standardized developmental screening in 2 months and reassess trajectory
D. Refer to early intervention and audiology for language delay evaluation

7. A 30-month-old boy is brought to the office for a well-child visit. His father is concerned because the child does not yet speak in sentences. Review of developmental milestones shows the following findings: Domain Current Abilities Expected by 24 Months Expected by 36 Months Language 15 single words, no phrases Two-word phrases, 50+ words Three-word sentences, 200+ words Social Points, shares toys, parallel play Parallel play, imitates adults Cooperative play, takes turns Motor Runs well, kicks ball, walks stairs Runs, kicks ball, walks stairs Rides tricycle, alternates feet on stairs Cognitive Names pictures, sorts shapes Follows two-step commands Knows colors, understands concepts

A. Significant language delay with normal social and motor development
B. Global developmental delay affecting language, social, and motor domains equally
C. Age-appropriate development across all domains with expected milestone achievement
D. Social communication disorder with impaired parallel play and sharing behaviors

8. A 30-year-old woman, gravida 2, para 1, at 28 weeks' gestation comes to the office for a routine prenatal visit. She received Tdap vaccine during her first pregnancy 3 years ago. She received her annual influenza vaccine 2 weeks ago. She asks about vaccinations needed during this pregnancy to protect her newborn. Her immunization record shows she is up to date on all routine adult vaccines. Which of the following is the most appropriate recommendation regarding pertussis vaccination?

A. Defer Tdap vaccination until after delivery since she received it within 3 years
B. Administer Tdap vaccine at the 6-week postpartum visit along with other catch-up vaccines
C. Administer Tdap vaccine during this pregnancy, preferably at 27-36 weeks' gestation
D. No additional Tdap needed since she received it during her previous pregnancy

9. An 8-month-old girl is brought to the office for evaluation of inadequate weight gain. Her mother reports the infant is breastfed on demand but seems uninterested in feeding and often falls asleep after a few minutes. The family recently moved and the mother admits to feeling overwhelmed and isolated. Birth weight was 3.2 kg (50th percentile). Current weight is 6.0 kg (below 5th percentile for age). Physical examination shows a thin infant with decreased subcutaneous fat but no edema, organomegaly, or dysmorphic features. She is alert but does not smile readily. Which of the following is the most appropriate initial evaluation approach? Evaluation Component Specific Elements Priority History Feeding schedule, intake volume, formula preparation, caregiver stress, food insecurity High Physical Exam Signs of chronic disease (cardiac murmur, hepatomegaly), skin changes, developmental assessment High Initial Labs CBC, comprehensive metabolic panel, urinalysis, thyroid function Medium Specialized Testing Sweat chloride, celiac panel, imaging studies Low (if above unrevealing)

A. Immediate laboratory evaluation including CBC, metabolic panel, and thyroid studies
B. Referral to pediatric gastroenterology for endoscopy and specialized testing
C. Focus exclusively on organic causes with cardiac evaluation and sweat chloride test
D. Schedule follow-up in 2 weeks to reassess weight before initiating any workup

10. A 2-week-old infant is brought to the office for a routine health supervision visit. The parents are first-time parents and ask for guidance on keeping their baby safe. The infant was born at term with no complications and is exclusively breastfed. Physical examination shows a healthy-appearing newborn with normal growth parameters. Which of the following safety counseling topics is most appropriate to emphasize at this visit?

A. Water safety including constant supervision during bath time and pool fencing
B. Supine sleep position in smoke-free environment with firm sleep surface
C. Choking hazards and safe introduction of solid foods starting at 4 months
D. Rear-facing car seat installation and never leaving infant alone in vehicle

11. A 20-month-old boy is brought to the office for a routine well-child visit. The parents express concern that he is not yet speaking in two-word phrases like his older sibling did at this age. Developmental surveillance at previous visits showed age-appropriate gross motor and social skills. The child makes good eye contact, points to objects of interest, and engages in pretend play. Physical examination shows no abnormalities. Hearing screening at 12 months was normal. The physician administers a standardized developmental screening tool, which yields scores within normal limits for all domains. However, the parents remain concerned about the language delay. Which of the following is the most appropriate next step in management? Age (months) Recommended Screening Action if Concern Present 9 General developmental surveillance Document, educate, follow-up 18 General developmental + autism-specific (M-CHAT) Refer to early intervention if delays; repeat autism screen at 24 months 24 General developmental + autism-specific (M-CHAT) Refer to early intervention and audiology if speech delay; developmental pediatrics if red flags 30 General developmental surveillance Refer as indicated by findings

A. Refer immediately to developmental pediatrics for autism spectrum disorder evaluation
B. Repeat the standardized screening tool in 3 months to confirm findings
C. Provide speech and language stimulation techniques and reassess at 24-month visit
D. Refer to early intervention services and audiology for hearing evaluation

12. A 30-month-old girl is brought to the office because her parents noticed that over the past 2 months she has stopped using the 10–15 words she previously spoke consistently. She previously responded to her name and waved goodbye but no longer does so. She was walking independently at 14 months but now has an unsteady gait. Growth parameters show weight and height at the 40th percentile, unchanged from prior visits. Temperature is 37.0°C (98.6°F), pulse is 110/min, and blood pressure is 95/60 mm Hg. Physical examination shows mild hypotonia and intermittent hand-wringing movements. The child does not make eye contact during the examination. Which of the following is the most appropriate next step in management?

A. Urgent referral to pediatric neurology for evaluation of regression
B. Schedule follow-up in 2 months to monitor for further developmental changes
C. Refer to physical therapy for evaluation and management of gait abnormality
D. Refer to early intervention services and reassess in 3 months

13. A 13-year-old girl comes to the office for a health maintenance visit. She has no chronic medical conditions and takes no medications. Immunization records show she completed the primary infant series and received DTaP, IPV, MMR, and varicella boosters at age 5 years. She has not received any vaccines since then. Her last influenza vaccination was 2 years ago. Which of the following vaccine combinations is most appropriate to administer today? Vaccine Recommended Age Minimum Interval if Catch-up Needed Tdap booster 11–12 years If no Td/Tdap since age 7, give now HPV series (2 or 3 doses) 11–12 years (can start at 9) If started <15 years: 2 doses, 6–12 months apart; ≥15 years: 3 doses MenACWY 11–12 years, booster at 16 4 weeks between doses if catch-up Influenza Annually, ≥6 months Annual, regardless of prior doses

A. Tdap, HPV series (complete 3-dose series today), and influenza vaccine
B. Influenza vaccine only; schedule follow-up for remaining adolescent vaccines
C. Tdap, HPV (first dose), MenACWY, and influenza vaccine
D. Tdap, MenACWY, and influenza vaccine; defer HPV until age 15 years

14. A 15-month-old boy is brought to the office for a well-child visit. The mother reports he has been a picky eater for the past 4 months, often refusing meals and preferring to drink whole milk throughout the day. Serial growth measurements are shown below. Physical examination shows a pale, active toddler with no organomegaly or dysmorphic features. Which of the following is the most likely cause of the growth pattern? Age (months) Weight (percentile) Length (percentile) Weight-for-Length 6 50th 50th 50th 9 40th 50th 25th 12 25th 48th 10th 15 15th 47th 5th

A. Chronic systemic illness causing failure to thrive
B. Growth hormone deficiency affecting linear growth
C. Celiac disease with malabsorption of nutrients
D. Constitutional growth delay with familial short stature

15. A 16-year-old girl comes to the office without her parents for a health maintenance visit. During the confidential portion of the visit, she reports she has been sexually active with her boyfriend for 3 months and asks about contraception. She also mentions feeling sad and having difficulty sleeping for the past month but asks the physician not to tell her parents because "they will be upset." She denies suicidal ideation, self-harm, or feeling unsafe at home. Which of the following is the most appropriate initial response by the physician?

A. Prescribe contraception today and schedule follow-up for mental health evaluation in 2 weeks
B. Address contraception and mental health; maintain confidentiality unless safety concerns arise
C. Inform her that you must discuss both issues with her parents due to her age
D. Provide contraception counseling but defer mental health discussion to a separate visit

16. A 28-month-old boy is brought to the office because of delayed speech development. He says fewer than 10 single words and does not combine words. He walked at 16 months. He plays with toys appropriately, makes eye contact, and points to desired objects. Physical examination shows no abnormalities. Hearing screening at 18 months was normal. Standardized developmental screening confirms isolated expressive language delay. Which of the following is the most appropriate next step in management?

A. Refer to audiology for comprehensive hearing evaluation and await results before further referrals
B. Refer to a pediatric speech-language pathologist for evaluation and therapy
C. Refer to developmental pediatrics for comprehensive evaluation before initiating services
D. Refer to early intervention services and audiology for repeat hearing evaluation

17. A 9-month-old girl is brought to the office for a well-child visit. The mother reports the child is "doing everything her older brother did at this age." During the visit, the physician asks the mother whether the child can sit without support, transfer objects between hands, and respond to her name. The mother answers yes to all questions. The physician does not directly observe these milestones during the examination. Based on this assessment approach, which of the following potential issues is most likely? Assessment Method Reliability Potential Pitfall Parental recall only Moderate Recall bias; overestimation of skills Direct observation High Limited by time and setting Standardized screening tool High Requires administration time; may miss context Combined approach (tool + observation) Highest Time-intensive but most accurate

A. Misclassification of development due to parental recall bias
B. Increased parental engagement and awareness of developmental milestones
C. Failure to identify subtle delays that require immediate subspecialty referral
D. Overuse of diagnostic testing due to lack of objective assessment

18. A 2-month-old boy is brought to the office for his first well-child visit since hospital discharge. He was born at 39 weeks' gestation via uncomplicated vaginal delivery. Birth weight was 3.2 kg (7 lb). He received hepatitis B vaccine at birth. The mother is healthy and has no history of immunocompromising conditions. She reports the infant is feeding well and has no concerns. Physical examination shows a healthy, thriving infant with no abnormalities. Which of the following vaccine combinations is most appropriate to administer today?

A. DTaP, Hib, and PCV13 only; schedule follow-up for remaining vaccines in 2 weeks
B. DTaP, Hib, IPV, PCV13, and rotavirus; hepatitis B series starts at 6 months
C. DTaP, Hib, IPV, PCV13, rotavirus, and hepatitis B
D. DTaP, Hib, IPV, PCV13, and hepatitis B; defer rotavirus until 4 months

19. A 22-month-old boy is brought to the office because of poor weight gain. He was born at term with no complications. Growth chart review shows weight dropping from the 40th percentile at 12 months to below the 5th percentile currently; length remains at the 35th percentile. The parents report he eats small amounts at meals and drinks 32 oz of whole milk daily. The family has limited financial resources. Physical examination shows a thin, irritable toddler with conjunctival pallor. Which of the following is the most appropriate initial evaluation? Evaluation Component Indication Priority Detailed dietary history Assess intake, food access High Complete blood count Evaluate for anemia High Basic metabolic panel Assess for electrolyte abnormalities, renal function Moderate Thyroid function tests Screen for hypothyroidism if growth velocity low Moderate Stool studies Evaluate for malabsorption if diarrhea present Low (as initial test) Social work referral Address food insecurity, access to resources High

A. Detailed dietary history, complete blood count, and nutrition referral for feeding plan
B. Immediate hospitalization for further evaluation and nutritional rehabilitation
C. Complete blood count, comprehensive metabolic panel, thyroid tests, celiac serology, stool studies, and abdominal imaging
D. Dietary counseling to limit milk intake and increase solid foods; follow-up in 1 month

20. A 2-year-old boy is brought to the office for a health maintenance visit. The parents report he has frequent temper tantrums when limits are set. They ask for advice on discipline strategies. They also mention he watches 4 hours of television daily while the parents work from home. The family has a swimming pool in the backyard. Which of the following anticipatory guidance topics is most appropriate to address during this visit?

A. Provide handout on toddler development and schedule follow-up if behavioral concerns persist
B. Positive discipline techniques, screen time limits, and water safety
C. Positive discipline techniques and screen time limits; defer safety topics to next visit
D. Positive discipline techniques, water safety, and car seat positioning for forward-facing transition

21. A 14-month-old boy is brought to the office by his parents for a well-child visit. The parents express concern that he is not yet walking independently and is only saying 'mama' and 'dada.' They report that he can pull to stand and cruise along furniture but does not take independent steps. He feeds himself finger foods and uses a pincer grasp. He waves bye-bye and plays peek-a-boo. His older sibling walked at 11 months. Medical history is unremarkable; the child was born at term via uncomplicated vaginal delivery. Physical examination shows no dysmorphic features. Neurologic examination reveals normal tone and strength. You perform a standardized developmental screening tool, which shows age-appropriate results in all domains. After explaining typical developmental variations and documenting the parents' concerns, which of the following is the most appropriate next step in management?

A. Reassure the parents that independent walking by 18 months is normal and no follow-up is needed unless concerns persist
B. Schedule a routine follow-up visit in 6 months at the 18-month well-child check to reassess developmental progress
C. Repeat the developmental screening tool at the end of today's visit to confirm the initial age-appropriate findings
D. Schedule a follow-up visit in 4–6 weeks to reassess motor milestones and provide anticipatory guidance on injury prevention

22. A 6-month-old girl is brought to the office for a routine well-child visit. The parents report that she seems 'floppy' compared to her older brother at the same age. She has poor head control when pulled to sit and does not bear weight on her legs when held upright. She does not roll over in either direction. The parents note that she does not seem to track moving objects consistently and does not turn her head toward sounds. She was born at 38 weeks' gestation via cesarean delivery for breech presentation. Birth weight was 2.9 kg (6 lb 6 oz). She is breastfed exclusively. Temperature is 37.0°C (98.6°F), pulse is 120/min, and respirations are 32/min. Physical examination shows generalized hypotonia with decreased resistance to passive movement. Deep tendon reflexes are 1+ and symmetric. The infant does not visually fix on the examiner's face or follow a bright red toy moved across her visual field. She does not turn toward a rattle shaken near her ear. Which of the following is the most appropriate next step in management?

A. Urgent referral to pediatric neurology for comprehensive evaluation of hypotonia and sensory deficits

B. Schedule a follow-up visit at the 9-month well-child check to reassess tone and tracking after allowing more time for development

C. Refer to pediatric ophthalmology for formal visual acuity testing and funduscopic examination to evaluate tracking deficits

D. Initiate physical therapy referral for strengthening exercises and provide reassurance that hypotonia often improves by 12 months

23. A 28-year-old woman, gravida 2 para 1, comes to the office for her first prenatal visit at 10 weeks' gestation. She plans to continue working full-time throughout her pregnancy. Her previous pregnancy was uncomplicated, and she delivered a healthy infant at term 3 years ago. She has no chronic medical conditions and takes only a prenatal vitamin. She asks about recommended vaccinations during pregnancy. It is early October, and influenza activity has been reported in the region. She received an inactivated influenza vaccine 14 months ago. She recalls receiving a tetanus booster approximately 6 years ago but is unsure whether it contained pertussis vaccine. The table below summarizes current vaccine recommendations during pregnancy. Vaccine First Trimester Second Trimester Third Trimester Notes Inactivated Influenza Recommended during flu season Recommended during flu season Recommended during flu season Any trimester if flu season Tdap (Tetanus, Diphtheria, Pertussis) Not routinely given Not routinely given Recommended at 27–36 weeks Optimal timing for neonatal protection Live Attenuated Vaccines (MMR, Varicella) Contraindicated Contraindicated Contraindicated Avoid during entire pregnancy

A. Administer inactivated influenza vaccine today; defer Tdap until after delivery since she had tetanus booster 6 years ago

B. Defer inactivated influenza vaccine until second trimester; administer live attenuated influenza vaccine today for better early immunity

C. Administer inactivated influenza vaccine today; plan Tdap at 27–36 weeks

D. Defer both influenza and Tdap vaccines until the third trimester to avoid any potential first-trimester risks

24. A 3-year-old boy is brought to the office for a routine well-child visit. The parents report that he eats a varied diet but is 'smaller than other kids his age.' He was born at term with normal birth parameters. He has been healthy with no chronic illnesses. Developmental milestones have been age-appropriate. Physical examination shows a well-appearing child with no dysmorphic features. Growth measurements over the past 18 months are plotted on standardized U.S. growth charts and shown in the table below. Age (months) Weight-for-Age Percentile Length/Height-for-Age Percentile BMI-for-Age Percentile 18 45th 50th 40th 24 35th 48th 25th 30 20th 45th 10th 36 15th 42nd 8th

A. Reassure the parents that the child's growth is within normal limits since all measurements remain above the 5th percentile

B. Schedule a follow-up visit in 6 months to continue monitoring growth trends before initiating any diagnostic workup

C. Refer to pediatric endocrinology for growth hormone testing given the decline in height-for-age percentile over time

D. Recommend high-calorie nutritional supplements and recheck growth parameters in 3 months to assess response to intervention

25. A 2-week-old girl is brought to the office for a newborn follow-up visit. The parents are first-time parents and ask for guidance on keeping their daughter safe at home and during car travel. The infant was born at term via uncomplicated vaginal delivery and is breastfeeding well. The parents live in a two-story home and have purchased a convertible car seat. The father smokes cigarettes but reports he only smokes outside the house. The mother's brother died in a house fire when she was a child, and she is anxious about fire safety. Physical examination shows a well-appearing infant with normal vital signs and age-appropriate reflexes. Which of the following is the most appropriate safety counseling for this family?

A. Keep the infant in the parents' bed for the first 6 months to facilitate breastfeeding and allow close monitoring for safety concerns

B. Keep the infant rear-facing in the car seat until at least age 2 years and establish a smoke-free home environment

C. Transition the infant to a forward-facing car seat at 1 year of age when she can sit independently and walk with support

D. Install smoke detectors on both floors and develop a fire escape plan; defer car seat and smoking guidance to the 2-month visit

26. A 20-month-old boy is brought to the office by his mother for a routine well-child visit. She reports that he is not yet speaking in two-word phrases and does not point to objects of interest. She has completed a validated developmental screening questionnaire (Ages and Stages Questionnaire), which shows scores in the normal range for all domains. However, the mother states, 'I just feel like something is not right with his development compared to other children his age.' She mentions that her nephew was diagnosed with autism spectrum disorder and she is worried her son may have similar issues. Physical examination shows a healthy-appearing toddler who makes inconsistent eye contact and does not respond when his name is called. Which of the following is the most appropriate next step in management?

A. Repeat the Ages and Stages Questionnaire in the office today to confirm the normal results and address the mother's anxiety

B. Schedule a follow-up visit in 6 months to reassess language development and social interaction before considering referral

C. Administer an autism-specific screening tool (M-CHAT) and defer referral unless this second screening is also abnormal

D. Refer for comprehensive developmental evaluation despite the normal screening results

27. A 22-month-old girl is brought to the office because her parents are concerned about her language development. She says only 10–15 single words and does not combine words into phrases. She can follow simple one-step commands such as 'give me the ball' but cannot follow two-step commands. The parents report that she plays alongside other children at daycare but does not interact with them directly. She enjoys playing with toys, makes good eye contact, and points to objects she wants. She can stack four blocks, feed herself with a spoon, and remove her shoes. Medical history is unremarkable. Physical examination shows a well-appearing child with normal hearing screen results. The table below compares the child's current milestones to typical 18–24 month expectations. Domain Patient's Skills Expected by 24 Months Expressive Language 10–15 single words, no phrases Two-word phrases, 50+ words Receptive Language Follows one-step commands Follows two-step commands Social Interaction Parallel play, good eye contact, points Parallel play, beginning cooperative play Fine Motor Stacks 4 blocks, uses spoon Stacks 6+ blocks, turns pages Gross Motor Walks well, kicks ball Runs, walks up stairs with rail

A. Refer to speech-language pathology for isolated expressive language delay

B. Refer for comprehensive autism spectrum disorder evaluation given language delay and preference for parallel play over cooperative play

C. Provide reassurance and schedule follow-up at 30 months, as many children catch up in language by age 3 without intervention

D. Refer to audiology for formal hearing evaluation despite normal hearing screen, as subtle hearing loss can cause isolated language delay

28. A 5-year-old boy is brought to the office for a pre-kindergarten physical examination. Immunization records show he received DTaP doses at 2, 4, and 6 months of age, but his parents moved to another state and he missed his 15–18 month booster. He has had no doses since 6 months of age. He has no known allergies and has been healthy. The parents want to complete his immunizations before school entry. Physical examination shows a well-appearing child with normal vital signs. According to current CDC catch-up immunization guidelines, which of the following is the most appropriate DTaP vaccination schedule for this patient?

A. Administer DTaP dose 4 today; schedule dose 5 in 4 weeks to complete the series before kindergarten starts in 2 months

B. Administer one DTaP dose today to complete the series, as children who received three doses in infancy require only one additional dose

C. Administer DTaP dose 4 today; administer dose 5 at least 6 months later at age 5–6 years

D. Administer DTaP doses 4 and 5 today to rapidly achieve immunity before school entry, as he has had no doses in over 4 years

29. A 10-month-old girl is brought to the office for a routine well-child visit. The parents ask about introducing new foods. The infant currently drinks formula and eats pureed vegetables, fruits, and rice cereal. She has no known food allergies. The parents have been advised by relatives to avoid certain foods until the child is older. The mother's sister had a severe anaphylactic reaction to peanuts as a child. The parents ask specifically about when they can introduce honey, cow's milk, and peanut-containing foods. Which of the following nutritional guidance recommendations is most appropriate?

A. Introduce honey now as a natural sweetener; avoid peanut-containing foods until age 3 years due to family history of peanut allergy

B. Avoid honey until 18 months; introduce whole cow's milk now to ensure adequate calcium and vitamin D intake for bone development

C. Introduce honey and peanut-containing foods now; wait until 24 months for cow's milk to minimize gastrointestinal upset and allergy risk

D. Avoid honey permanently due to contamination risk; introduce cow's milk and peanut-containing foods simultaneously at 12 months of age

30. An 18-month-old boy is brought to the office because of parental concern about developmental regression. The parents report that he could say 10 words at 15 months but now uses only 3 words. He previously walked well but now trips frequently and seems unsteady. He has lost interest in playing with toys and often stares blankly. Appetite has decreased and he has lost 0.5 kg (1.1 lb) over 2 months. He was born at term with normal development until 15 months. Physical examination shows a thin, pale child with poor eye contact. Weight has dropped from the 40th to the 15th percentile; length remains at the 50th percentile. Neurologic examination shows generalized hypotonia and brisk deep tendon reflexes. He does not respond to his name. The table below outlines the recommended evaluation approach. Referral/Evaluation Priority Level Rationale Pediatric neurology Urgent Regression and abnormal tone/reflexes Developmental pediatrics Urgent Multidomain regression assessment Metabolic/genetic workup Urgent Rule out inborn errors, storage diseases Nutrition assessment High Weight loss crossing percentiles Audiology Routine Assess hearing as part of comprehensive evaluation

A. Initiate high-calorie nutritional supplementation and physical therapy; reassess in 2 months to determine if regression persists despite intervention

B. Urgent neurology and developmental pediatrics referrals with concurrent metabolic workup and nutrition assessment

C. Refer to developmental pediatrics for autism spectrum disorder evaluation; defer neurology referral unless developmental assessment is abnormal

D. Order lead level and complete blood count to evaluate for environmental exposure and iron deficiency anemia causing developmental delay

Answer Key & Explanations

1. D — Immediate referral to early intervention and audiology evaluation
This 15-month-old has significant red flags: no single words by 15 months (expected by 12 months), limited social engagement, and not responding to name. These findings warrant immediate referral to early intervention (IDEA Part C) and audiology evaluation to rule out hearing loss. Distractor1 delays necessary intervention. Distractor2 is premature for autism-specific screening before 18 months. Distractor3 inappropriately delays action. Distractor4 misses the need for audiology assessment when language delay is present.

2. A — Absent babbling and poor social smile at 7 months
Red flags warranting urgent evaluation include no social smile by 2 months and no babbling by 9 months. At 7 months, absent babbling combined with poor social engagement (rarely smiles, inconsistent eye contact) represents significant delay in multiple domains requiring immediate assessment. Distractor1 describes normal development (sitting independently expected 6-9 months). Distractor2 reflects normal fine motor development (raking grasp appropriate for age). Distractor3 is less concerning as independent walking develops 9-15 months. Distractor4 describes normal variation in language timeline.

3. C — Administer DTaP today, then MMR and varicella together in 4 weeks
Inactivated vaccines (DTaP) can be given immediately. Live vaccines (MMR, varicella) require waiting at least 3 months after severe immunosuppression ends; at 6 months post-chemotherapy, he is eligible. Live vaccines must be spaced 28 days apart if not given concurrently, so MMR and varicella should be administered together. Distractor1 violates the 28-day spacing rule for sequential live vaccines. Distractor2 incorrectly continues contraindication beyond necessary timeframe. Distractor3 inappropriately delays inactivated vaccine. Distractor4 violates live vaccine spacing requirements.

4. A — Weight and length both declining proportionally from 50th to 25th percentile
Concerning growth pattern is crossing two major percentile lines (75th to 5th) over a short interval, indicating failure to thrive. Weight deceleration is disproportionate to length, suggesting inadequate caloric intake rather than genetic short stature. This requires comprehensive evaluation including feeding history, psychosocial assessment, and laboratory studies. Distractor1 describes normal proportional growth. Distractor2 represents constitutional growth variant. Distractor3 shows stable percentiles. Distractor4 misinterprets the data pattern.

5. B — Perform confidential screening for depression and risky behaviors, then discuss contraception
Adolescent visits require confidential screening for depression, sexual behavior, and substance use per HEEADSSS assessment guidelines. The patient's request for contraception and report of stress warrant depression screening before prescribing. State laws generally allow minors to consent for reproductive health services. Distractor1 violates confidentiality and adolescent autonomy. Distractor2 misses depression screening opportunity. Distractor3 focuses on less immediate concern. Distractor4 is premature without comprehensive screening and counseling first.

6. D — Refer to early intervention and audiology for language delay evaluation
A 20-month-old should have 10-25 words and be starting to combine two words (expected by 24 months).

Isolated language delay with normal social and motor skills still requires early intervention referral (IDEA Part C) and audiology evaluation to rule out hearing loss. Early intervention maximizes outcomes. Distractor1 inappropriately delays intervention beyond critical window. Distractor2 misses the early intervention opportunity. Distractor3 is premature without hearing evaluation. Distractor4 represents watchful waiting when action is indicated.

7. A — Significant language delay with normal social and motor development
This child has isolated expressive language delay (no two-word phrases by 30 months, expected by 24 months) but normal social (parallel play, sharing) and motor milestones (runs, kicks ball, stairs). This pattern suggests specific language impairment rather than global developmental delay or autism. Requires early intervention and audiology referral. Distractor1 mischaracterizes as global delay when other domains are appropriate. Distractor2 describes normal development. Distractor3 incorrectly identifies autism when social skills are intact. Distractor4 reverses the delay pattern.

8. C — Administer Tdap vaccine during this pregnancy, preferably at 27-36 weeks' gestation
Tdap is recommended during each pregnancy (preferably 27-36 weeks) to maximize transplacental antibody transfer and provide neonatal pertussis protection, regardless of previous vaccination history. Maternal antibodies wane, so repeat vaccination optimizes infant protection during vulnerable early months before infant series completion. Distractor1 is outdated guidance (one-time adult Tdap no longer sufficient for pregnancy). Distractor2 misses optimal timing for antibody transfer. Distractor3 represents inappropriate delay. Distractor4 confuses postpartum timing with prenatal recommendation.

9. A — Immediate laboratory evaluation including CBC, metabolic panel, and thyroid studies
Most failure to thrive cases result from inadequate caloric intake due to psychosocial factors (food insecurity, caregiver depression, feeding problems) rather than organic disease. Initial evaluation should focus on detailed feeding history, observation of feeding, and assessment of psychosocial stressors before extensive laboratory workup. The mother's report of feeling overwhelmed and the infant's disinterest in feeding suggest psychosocial contributors. Distractor1 is premature without history. Distractor2 represents overly aggressive testing. Distractor3 misses psychosocial factors. Distractor4 delays necessary nutritional intervention.

10. B — Supine sleep position in smoke-free environment with firm sleep surface
For newborns and young infants, safe sleep counseling (supine position, firm surface, no soft bedding, smoke-free environment) is the highest priority to reduce SIDS risk. This is evidence-based injury prevention for this age group. Distractor1 addresses older infant safety (6+ months for solid foods). Distractor2 is important but less immediately relevant than safe sleep. Distractor3 is appropriate for toddlers. Distractor4 applies to older infants who are mobile.

11. D — Refer to early intervention services and audiology for hearing evaluation
Despite normal screening scores, parental concern about language development warrants action. Guidelines recommend referral to early intervention (IDEA Part C for children under 3) and audiology evaluation when speech or language delays are present, even if autism-specific screening is normal. Early intervention does not require a diagnosis. Distractor 1 delays necessary evaluation. Distractor 2 is premature without hearing and developmental assessments. Distractor 3 ignores valid parental concern. Distractor 4 inappropriately delays referral pending further observation.

12. A — Urgent referral to pediatric neurology for evaluation of regression
Loss of previously acquired skills (regression) is a red flag requiring urgent multidisciplinary evaluation by

developmental pediatrics or neurology. This child demonstrates regression in language, social skills, and motor function, plus abnormal movements—concerning for neurodevelopmental or neurometabolic disorders. Regression takes priority over additional screening. Distractor 1 inappropriately delays evaluation. Distractor 2 addresses only one aspect. Distractor 3 is insufficient for regression. Distractor 4 uses an autism screen when neurological evaluation is more urgent.

13. C — Tdap, HPV (first dose), MenACWY, and influenza vaccine
At age 13, this patient is due for Tdap (adolescent booster), HPV series initiation (recommended starting 11–12 years; she qualifies for the 2-dose schedule since starting before age 15), MenACWY (routine at 11–12 years), and annual influenza vaccine. All four are appropriate today. Distractor 1 omits HPV. Distractor 2 incorrectly includes MMR (already immune). Distractor 3 omits MenACWY. Distractor 4 suggests deferring vaccines that are currently due.

14. A — Chronic systemic illness causing failure to thrive
The child shows progressive weight deceleration (crossing percentile lines downward from 50th to 15th) while length remains stable near 50th percentile, and weight-for-length has declined to the 5th percentile. This pattern—poor weight gain with preserved linear growth—suggests inadequate caloric intake rather than systemic disease or endocrine disorder. The history of excessive milk intake and meal refusal supports this. Distractor 1 would show both weight and length deceleration. Distractor 2 would affect length more than weight. Distractor 3 typically presents with other findings. Distractor 4 would show weight gain, not loss.

15. B — Address contraception and mental health; maintain confidentiality unless safety concerns arise
Adolescents have the right to confidential discussions about sexual health and mental health screening. The physician should address both issues while respecting confidentiality, as there are no immediate safety concerns (no suicidal ideation or harm). If safety concerns emerge, confidentiality can be breached. Distractor 1 inappropriately breaches confidentiality without cause. Distractor 2 avoids addressing mental health. Distractor 3 defers necessary care. Distractor 4 prioritizes only one issue and delays mental health assessment.

16. D — Refer to early intervention services and audiology for repeat hearing evaluation
For a child under 3 years with identified speech delay, immediate referral to early intervention (IDEA Part C) is appropriate, along with audiology evaluation to rule out hearing loss, even if prior screening was normal. Early intervention provides speech therapy without requiring a diagnosis. Concurrent evaluations (audiology, EI) should not be delayed. Distractor 1 defers necessary services. Distractor 2 addresses only audiology. Distractor 3 is not the primary referral for children under 3. Distractor 4 delays specialist evaluation unnecessarily.

17. A — Misclassification of development due to parental recall bias
Relying solely on parental recall without direct observation or a validated screening tool risks misclassification. Parents may overestimate skills or misremember timing. Best practice combines parental report with direct observation and standardized tools to ensure accuracy. Distractor 1 is a benefit, not a risk. Distractor 2 is possible but less likely than misclassification. Distractor 3 is not the primary concern here. Distractor 4 is not a risk of this approach.

18. C — DTaP, Hib, IPV, PCV13, rotavirus, and hepatitis B
At 2 months, infants should receive the primary series: DTaP, Hib, IPV, PCV13, and rotavirus (all starting at 2

months), plus hepatitis B (second dose; first was at birth). All six vaccines are appropriate and can be administered simultaneously. Rotavirus is a live vaccine but is not contraindicated in healthy infants. Distractor 1 incorrectly omits rotavirus. Distractor 2 incorrectly includes MMR (not due until 12 months). Distractor 3 unnecessarily defers vaccines. Distractor 4 incorrectly omits hepatitis B.

19. A — Detailed dietary history, complete blood count, and nutrition referral for feeding plan
Initial evaluation of poor growth should include detailed dietary history, basic labs (CBC for anemia given pallor and excessive milk intake, metabolic panel), and addressing socioeconomic factors (social work for food insecurity). Excessive milk intake can cause iron deficiency anemia and displace solid foods. Distractor 1 omits essential metabolic evaluation. Distractor 2 is premature without basic workup. Distractor 3 includes too extensive testing initially. Distractor 4 omits labs and social support.

20. B — Positive discipline techniques, screen time limits, and water safety
For toddlers and preschoolers, key anticipatory guidance includes: discipline strategies (positive reinforcement, consistent limits for tantrums), screen time limits (AAP recommends <1 hour/day of high-quality programming for ages 2–5), and injury prevention including water safety (drowning is a leading cause of death; supervision and barriers are critical). All three topics are appropriate for this visit. Distractor 1 omits water safety. Distractor 2 includes unnecessary car seat detail and omits screen time. Distractor 3 includes irrelevant content. Distractor 4 defers important guidance.

21. D — Schedule a follow-up visit in 4–6 weeks to reassess motor milestones and provide anticipatory guidance on injury prevention
The correct approach documents parental concerns, acknowledges typical variation, and arranges short-term monitoring (4–6 weeks) while the screening is normal. This balances parental anxiety with watchful waiting, provides structured follow-up during any referral lag, and offers anticipatory guidance. Immediate referral is premature given the normal screening and the child's intact skills in other domains. Reassuring without follow-up ignores the parents' concern and misses documentation of their input. Waiting 6 months is too long when parents are actively worried. Repeating the screening at the same visit adds no new information and delays action.

22. A — Urgent referral to pediatric neurology for comprehensive evaluation of hypotonia and sensory deficits
Persistent hypotonia combined with poor visual tracking and absent auditory response are red flags requiring urgent neurology referral. These findings span multiple domains (motor, vision, hearing) and suggest a central nervous system disorder, metabolic condition, or genetic syndrome. Waiting for the 9-month visit delays critical evaluation. Ophthalmology alone does not address the hypotonia and hearing concerns. Physical therapy without diagnosis may miss a treatable underlying condition. Repeat developmental screening at the same visit will not change the examination findings that mandate referral.

23. C — Administer inactivated influenza vaccine today; plan Tdap at 27–36 weeks
Inactivated influenza vaccine is recommended in any trimester during flu season, so it should be given now at 10 weeks. Tdap is optimally administered at 27–36 weeks each pregnancy to maximize neonatal antibody transfer. Waiting until the third trimester for influenza vaccine misses early flu season protection. Giving both today is suboptimal because Tdap is not yet at the recommended gestational window. Deferring all vaccines risks missing flu season entirely and delays maternal pertussis immunity. Live vaccines are absolutely contraindicated during pregnancy.

24. A — Reassure the parents that the child's growth is within normal limits since all measurements remain above the 5th percentile
The child shows progressive downward crossing of weight and BMI percentiles (45th→15th for weight, 40th→8th for BMI) over 18 months, indicating growth deceleration that warrants evaluation for malabsorption, endocrine disorders, or chronic illness. Height percentile is relatively stable, but weight and BMI declines are concerning. Reassurance is inappropriate when percentiles are crossing downward. Waiting 6 months delays investigation of a concerning trend. Referral to endocrinology is premature before basic laboratory workup. High-calorie supplementation without evaluation may mask an underlying disorder.

25. B — Keep the infant rear-facing in the car seat until at least age 2 years and establish a smoke-free home environment
Current recommendations advise rear-facing car seats until at least age 2 or per manufacturer height/weight limits, as this provides optimal head and neck protection. Smoke-free home counseling is critical because thirdhand smoke residue on clothing and surfaces still exposes infants to toxins. Forward-facing at 1 year is outdated guidance. Installing smoke detectors is appropriate but does not address the car seat question. Bassinets are safe for supervised sleep but co-sleeping increases SIDS risk. Room-sharing without bed-sharing is recommended.

26. D — Refer for comprehensive developmental evaluation despite the normal screening results
Parental concern has high predictive value for developmental disorders and should prompt further evaluation even when screening tools are normal. The combination of maternal worry, family history of autism, poor eye contact, and absent response to name warrants referral. Overreassuring when a parent expresses concern dismisses valid input and may delay diagnosis. Repeating the same screening tool will likely yield the same result. Waiting 6 months risks missing the critical early intervention window. Autism-specific screening is appropriate but should accompany, not replace, comprehensive evaluation.

27. A — Refer to speech-language pathology for isolated expressive language delay
The child demonstrates isolated expressive language delay with intact social skills (eye contact, pointing, parallel play) and normal receptive language, motor, and hearing. This pattern is consistent with a 'late talker' rather than autism spectrum disorder, which would show social communication deficits. Speech therapy referral is appropriate. Comprehensive autism evaluation is not indicated given strong social skills. Watchful waiting until age 3 delays early intervention. Audiology referral is unnecessary since hearing screening was normal. Developmental pediatrics is premature before speech therapy trial.

28. C — Administer DTaP dose 4 today; administer dose 5 at least 6 months later at age 5–6 years
The child received three primary DTaP doses but missed the 15–18 month booster (dose 4). Current catch-up guidelines require dose 4 now (minimum 6-month interval from dose 3 is satisfied) and dose 5 at 4–6 years with at least 6 months between doses 4 and 5. Giving both doses today violates minimum interval requirements. Waiting until age 6 for dose 4 delays needed immunity. Administering dose 5 in 4 weeks does not respect the 6-month minimum interval. The 5-dose series is required; stopping at 4 doses is incomplete.

29. A — Introduce honey now as a natural sweetener; avoid peanut-containing foods until age 3 years due to family history of peanut allergy
Honey should be avoided until 12 months due to infant botulism risk from Clostridium botulinum spores. Cow's milk as a primary beverage is not recommended until 12 months, though small amounts in food are acceptable. Peanut-containing foods should be introduced around 6 months (especially with family history of allergy) to reduce allergy risk. Introducing honey at 10 months risks botulism. Cow's milk before 12 months

increases risk of iron deficiency and renal solute load. Delaying peanut introduction to 3 years is outdated and increases allergy risk.

30. B — Urgent neurology and developmental pediatrics referrals with concurrent metabolic workup and nutrition assessment
Developmental regression (loss of language and motor skills) combined with abnormal neurologic findings, poor growth, and behavioral changes requires urgent multidisciplinary evaluation. Neurology addresses tone/reflex abnormalities, developmental pediatrics coordinates comprehensive assessment, metabolic workup screens for treatable conditions (e.g., leukodystrophies, storage diseases), and nutrition addresses growth failure. Deferring neurology delays critical diagnosis. Autism evaluation alone misses the regression and neurologic signs. Lead screening and iron studies are appropriate but insufficient for this complex presentation. MRI without specialist coordination may miss clinical context.

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