

18 month - well child care

Patient Name: _____ **D.O.B** _____

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? _____

Does your child attend daycare? _____ Yes No

Development

Tries to say at least 3 words besides mama or dada _____ Yes No

Follows 1-step directions without any gestures, like giving _____ Yes No
you the toy when you say "Give it to me."

Copies you doing chores, like sweeping with a broom _____ Yes No

Plays with toys in a simple way, like pushing a toy car _____ Yes No

Walks without holding on to anyone or anything _____ Yes No

Scribbles _____ Yes No

Drinks from a cup without a lid and may spill sometimes _____ Yes No

Feeds themselves with their fingers _____ Yes No

Climbs on and off a couch or chair without help _____ Yes No

Moves away from you, but looks to make sure you are close by _____ Yes No

Points to show you something interesting _____ Yes No

Puts hands out for you to wash them _____ Yes No

Looks at a few pages in a book with you _____ Yes No

Helps you dress them by pushing arm through sleeve or lifting up foot _____ Yes No

Nutrition

Does your child drink milk? If so what kind _____ Whole Milk Soy Milk Other _____

Do they drink approximately 16oz (480ml) per day? _____ Yes No

Avoiding excess added sugars (juice, candy, sweets) and animal fats? _____ Yes No

Consuming green vegetables? _____ Yes No

Bowel habits

How many stools does you child have per day? _____

What do the stools look like (soft, formed, hard)? _____

Sleep Pattern

Sleeps throughout the night in their own crib? _____ Yes No

Safety

Is your child's car seat rear facing and in the back seat? _____ Yes No

Is your child exposed to tobacco smoke? _____ Yes No

Are there any improperly stored firearms in the home? _____ Yes No

Is the home childproofed? _____ Yes No

Is the hot water temperature set low enough
to prevent accidental burns? _____ Yes No

Are there working smoke detectors in the home? _____ Yes No

Please share any concerns that you have about your child here:

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Please complete both sides of this form