



Health Maintenance Questionnaire

15 MONTHS

PATIENT NAME _____ BIRTH DATE ____/____/____ AGE TODAY _____

PARENTS _____ TODAY'S DATE ____/____/____

PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION		PHYSICIAN'S COMMENTS	
H I S T O R Y	Describe any recent injuries or illnesses: _____	<input type="checkbox"/> Toilet training readiness, sitting with clothes first <input type="checkbox"/> Discussed risks of 2 nd hand smoke. <input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Brush teeth. Shaded items are new for the 15 mo check-up. FEEDING RECOMMENDATIONS <input type="checkbox"/> Whole milk until age 2. <input type="checkbox"/> Limit juices. <input type="checkbox"/> 3 meals per day + snacks. <input type="checkbox"/> Less appetite at this age. <input type="checkbox"/> Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins. <input type="checkbox"/> Manners are not important yet. <input type="checkbox"/> Wean off bottle. <input type="checkbox"/> Breast feeding may be weaned gently and gradually when Mom and baby are ready. TOILETING RECOMMENDATIONS <input type="checkbox"/> Defer toilet training until readiness signs appear (longer dry periods, dislikes soiled diaper, words). <input type="checkbox"/> Purchase potty chair. Can play on it clothed.	
	List medications taken routinely: <input type="checkbox"/> none		
	Note any new stresses in the family: _____		
	Is your child in day care? <input type="checkbox"/> No <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other: How many kids? _____		
N U T R I T I O N	Are there any smokers in your child's home or daycare? <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room		
	Does your child drink water that is fluoridated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
	How many ounces per day of Whole milk _____ Juice _____ How many servings per day of Meat _____ Fruit _____ Veggies _____		
	Y N <input checked="" type="checkbox"/> Are snacks scheduled? <input checked="" type="checkbox"/> Has your child tolerated all foods introduced? <input checked="" type="checkbox"/> Does your child self feed using fingers? <input checked="" type="checkbox"/> Is s/he starting to use a spoon and/or fork? <input checked="" type="checkbox"/> Does s/he drink well from a cup? <input checked="" type="checkbox"/> Is your child off of the bottle? If no, how many bottles per day? If nursing, how many times per day? _____		
Does your child pass stools without problems? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			

PHYSICAL EXAM		LAB	IMMUNIZATIONS
Ht _____ Wt _____ HC _____ VS: _____		<input type="checkbox"/> Hgb	<input checked="" type="checkbox"/> Given at Health Department
Check if normal:	<input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> Back <input type="checkbox"/> Mouth <input type="checkbox"/> Heart <input type="checkbox"/> Hips <input type="checkbox"/> Eyes/Red reflexes <input type="checkbox"/> Throat <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Extremities <input type="checkbox"/> Ears <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Neurologic <input type="checkbox"/> Chest <input type="checkbox"/> Genitalia	<input type="checkbox"/> Lead	Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____
		<input type="checkbox"/> PPD placed	<input type="checkbox"/> DTaP <input type="checkbox"/> HepB <input type="checkbox"/> IPV <input type="checkbox"/> Hib <input type="checkbox"/> Comvax <input type="checkbox"/> MMR <input type="checkbox"/> Prevnar <input type="checkbox"/> Varivax Other: _____
NOTE EXAM ABNORMALITIES HERE		Other: _____	

ASSESSMENT	PLAN
1. <input type="checkbox"/> NORMAL GROWTH and DEVELOPMENT. More information on other side.	1. <input type="checkbox"/> Follow up at 18 months for Health Review. <input type="checkbox"/> Anticipatory handouts given.
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Do you have concerns about your child's vision or hearing? Yes No

15 month

DEVELOPMENTAL ASSESSMENT	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's development?	
M O T O R	Y N <input checked="" type="checkbox"/> <input type="checkbox"/> Can your child walk alone, stop, start and stoop over? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he creep up stairs? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he scribble? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he stack 2 blocks?
	L A N G U A G E
	Y N <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child saying 3 to 6 words? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he use jargon and/or gestures? <input checked="" type="checkbox"/> <input type="checkbox"/> Can your child point to 1-2 body parts? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he follow 1 step commands? <input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he listen to a story book? <input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he point to pictures in books? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child enjoy singing songs? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit TV to less than 2 hours per day?
	S O C I A L
Y N <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child know proper use of objects, like placing a phone to the ear and a comb to the hair? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate behaviors such as playing with dolls, and sweeping and dusting? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he indicate wants by pulling, pointing, grunting or vocalizing? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child give hugs? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he frown when scolded?	

BEHAVIOR RECOMMENDATIONS	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's behavior?	
If these were reviewed previously, check this box. <input type="checkbox"/> You may skip to the "Sleep" box.	
Y N	
<input checked="" type="checkbox"/> <input type="checkbox"/> Is your child becoming more independent? (normal)	
<input checked="" type="checkbox"/> <input type="checkbox"/> Is your discipline consistent? (very important)	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you show affection regularly?	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-in frequently? (praising good behavior)	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-out? (removing attention when doing unacceptable behavior)	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you set limits and choose your battles wisely?	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you occasionally say "no?"	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?	
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you try to ignore tantrums? (very typical)	
S L E E P	Y N
	<input checked="" type="checkbox"/> <input type="checkbox"/> Does your child sleep well?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you maintain a bedtime routine?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Does your child nap once or twice daily? (typical)
	<input checked="" type="checkbox"/> <input type="checkbox"/> Have you lowered the crib mattress?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Are you OK with your child's use of self-comforting behaviors? <input type="checkbox"/> thumb sucking <input type="checkbox"/> pacifier <input type="checkbox"/> favorite object <input type="checkbox"/> None
	Where does your child usually sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 15 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.	
Y N	Y N
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you have window guards?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers?
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your doors locked?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations?
<input checked="" type="checkbox"/> <input type="checkbox"/> Is the car seat in the back seat? →	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on?
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous?
<input checked="" type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child?
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub?	<input checked="" type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees?
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan?
<input checked="" type="checkbox"/> <input type="checkbox"/> Do you have gates to guard the stairs?	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers?
	<input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?

TUBERCULOSIS (TB) RISK	
If you reviewed these TB risks previously and believe your child is still not at risk, check this box. <input type="checkbox"/> Skip to the "Lead Risk" box.	Y N <input type="checkbox"/> <input checked="" type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test? <input type="checkbox"/> <input checked="" type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America? <input type="checkbox"/> <input checked="" type="checkbox"/> Is anyone living in your house infected with HIV? <input type="checkbox"/> <input checked="" type="checkbox"/> Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers. <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?
	TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

LEAD RISK	
If you reviewed these Lead risks previously and believe your child is still not at risk, check this box. <input type="checkbox"/>	Y N <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child live in or visit a house built before 1978? <input type="checkbox"/> <input checked="" type="checkbox"/> Is there a sibling or playmate with lead poisoning? <input type="checkbox"/> <input checked="" type="checkbox"/> Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways? <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead? <input type="checkbox"/> <input checked="" type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?
	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

Who answered the above questions? _____ Thank you for helping us help you and your child!!
Please put this paper in the box hanging outside the door so that we know you are finished!