



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 |
|--|---|
| <p>HISTORY</p> <p>Describe any recent injuries or illnesses: _____</p> <p>List medications taken routinely: <input type="checkbox"/> none</p> <p>Note any new stresses in the family: _____</p> <p>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? _____</p> <p>Are there any smokers in your child's home or daycare? <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room</p> <p>Does your child drink water that is fluoridated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>NUTRITION</p> <p>How many ounces per day of Whole milk _____ Juice _____ How many servings per day of Meat _____ Fruit _____ Veggies _____</p> <p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Are snacks scheduled? <input checked="" type="checkbox"/> <input type="checkbox"/> Has your child tolerated all foods introduced? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child self feed using fingers? <input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting to use a spoon and/or fork? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he drink well from a cup? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child off of the bottle? If no, how many bottles per day? _____ If nursing, how many times per day? _____</p> <p>Does your child pass stools without problems? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p><input type="checkbox"/> Toilet training readiness, sitting with clothes first</p> <p><input type="checkbox"/> Discussed risks of 2nd hand smoke.</p> <p><input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Brush teeth.</p> <p>Shaded items are new for the 15 mo check-up.</p> <p>FEEDING RECOMMENDATIONS</p> <p><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.</p> <p>TOILETING RECOMMENDATIONS</p> <p><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.</p> |

| PHYSICAL EXAM | LAB | IMMUNIZATIONS | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|----------------------------------|---|--------------------------------------|-------------------------------|--|--------------------------------|--------------------------------|-------------------------------|-------------------------------|---------------------------------|---|--------------------------------------|--|-------------------------------|----------------------------------|-------------------------------|--|--------------------------------|------------------------------------|-------------------------------------|---|--|-------------------------------|-------------------------------|------------------------------|------------------------------|---------------------------------|------------------------------|----------------------------------|----------------------------------|
| <p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>Check if normal:</p> <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red reflexes</td> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Ears</td> <td><input type="checkbox"/> Throat</td> <td><input type="checkbox"/> Femoral pulses</td> <td><input type="checkbox"/> Extremities</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Genitalia</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p><small>NOTE EXAM ABNORMALITIES HERE</small></p> | <input type="checkbox"/> Head | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs | <input type="checkbox"/> Back | <input type="checkbox"/> Eyes/Red reflexes | <input type="checkbox"/> Mouth | <input type="checkbox"/> Heart | <input type="checkbox"/> Hips | <input type="checkbox"/> Ears | <input type="checkbox"/> Throat | <input type="checkbox"/> Femoral pulses | <input type="checkbox"/> Extremities | | <input type="checkbox"/> Neck | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Skin | | <input type="checkbox"/> Chest | <input type="checkbox"/> Genitalia | <input type="checkbox"/> Neurologic | <p><input type="checkbox"/> Hgb</p> <p><input type="checkbox"/> Lead</p> <p><input type="checkbox"/> PPD placed</p> <p>Other: _____</p> | <p><input checked="" type="checkbox"/> Given at Health Department</p> <p>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? _____</p> <table border="0"> <tr> <td><input type="checkbox"/> DTaP</td> <td><input type="checkbox"/> HepB</td> </tr> <tr> <td><input type="checkbox"/> IPV</td> <td><input type="checkbox"/> Hib</td> </tr> <tr> <td><input type="checkbox"/> Comvax</td> <td><input type="checkbox"/> MMR</td> </tr> <tr> <td><input type="checkbox"/> Prevnar</td> <td><input type="checkbox"/> Varivax</td> </tr> </table> <p>Other: _____</p> | <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 |
| <input type="checkbox"/> Head | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs | <input type="checkbox"/> Back | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Eyes/Red reflexes | <input type="checkbox"/> Mouth | <input type="checkbox"/> Heart | <input type="checkbox"/> Hips | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> Comvax | <input type="checkbox"/> MMR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Prevnar | <input type="checkbox"/> Varivax | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

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!