



# Health Maintenance Questionnaire

# 18 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
<b>HISTORY</b> Describe any recent injuries or illnesses: _____ 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? Are there any smokers in your child's home or daycare? <input checked="" 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 <b>NUTRITION</b> How many ounces per day of Whole milk _____ Juice _____ How many servings per day of Meat _____ Fruit _____ Veggies _____ <b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Are snacks scheduled? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child using a spoon and 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? Does your child pass stools without problems? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	☞ Toilet training readiness, sitting with clothes first  <input type="checkbox"/> Discussed risks of 2 <sup>nd</sup> hand smoke. <input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Brush teeth. <b>Shaded items are new for the 18 mo check-up.</b> <b>FEEDING RECOMMENDATIONS</b> <input type="checkbox"/> Whole milk until age 2. <input type="checkbox"/> Limit juices. <input type="checkbox"/> Regular family meals <input type="checkbox"/> Avoid meal time battles / 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"/> Should be off the bottle. <input type="checkbox"/> Breast feeding may be weaned gently and gradually when Mom and baby are ready. <b>TOILETING RECOMMENDATIONS</b> <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.

PHYSICAL EXAM	LAB	IMMUNIZATIONS
Ht _____ Wt _____ HC _____ VS: _____ Check if normal: <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"/> Neck <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Extremities <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Neurologic <input type="checkbox"/> Genitalia	<input type="checkbox"/> Hgb <input type="checkbox"/> Lead <input type="checkbox"/> PPD placed Other: _____	<input checked="" type="checkbox"/> Given at Health Department 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"/> 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: _____

### ASSESSMENT

1.  NORMAL GROWTH and DEVELOPMENT. More information on other side.

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

### PLAN

1.  Follow up at 2 years for Health Review.  Anticipatory handouts given.

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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

**18 month**

DEVELOPMENTAL ASSESSMENT	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's development?	
<b>M O T O R</b>	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child walk fast or run? <input checked="" type="checkbox"/> <input type="checkbox"/> Can your child walk backwards? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child walk up stairs with one hand held? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he climb into adult chairs? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he throw a ball? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he stack 3-4 blocks? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he scribble?
	<b>L A N G U A G E</b>
	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child say 4-10 words with meaning? <input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting to say 2 word phrases? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate words? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation? <input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he point to 5 body parts? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child enjoy singing songs? <input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he turn single pages when reading a book? <input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he name some pictures in a book? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit TV to less than 2 hours per day?
	<b>S O C I A L</b>
	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child appear to know what a comb is for? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate behaviors like sweeping and dusting? <input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting "pretend" play? <input checked="" type="checkbox"/> <input type="checkbox"/> Is sharing difficult for your child? (typical at this age) <input checked="" type="checkbox"/> <input type="checkbox"/> Do you ask your child to help pick up toys? <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child give hugs and kisses?

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.	
<b>Y N</b>	<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 try to give choices whenever it is reasonable? <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)
	<b>S L E E P</b>
	<b>Y N</b> <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"/> Are there night fears and awakenings? (typical) <input checked="" type="checkbox"/> <input type="checkbox"/> Does your child nap once or twice daily? (variable) <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 18 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor play near streets and driveways? <input checked="" type="checkbox"/> <input type="checkbox"/> Is your child always closely supervised in the house and car? <input checked="" type="checkbox"/> <input type="checkbox"/> Is the car seat in the back seat? →	<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Do you keep your doors locked? <input type="checkbox"/> <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers? <input type="checkbox"/> <input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations? <input type="checkbox"/> <input type="checkbox"/> Are sharp table edges protected? <input type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on? <input type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous? <input type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child? <input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach? <input type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers? <input type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?
<input type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach? <input type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub? <input type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets? <input type="checkbox"/> <input type="checkbox"/> Do you have gates to guard the stairs? <input type="checkbox"/> <input type="checkbox"/> Do you have window guards?	<b>Baby should be in a "convertible" car seat if over 20 lbs. The seat must still rear face if baby is less than 20 lbs. It can forward face if baby is over 20 lbs.</b>

TUBERCULOSIS (TB) RISK			
If you reviewed these TB risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/> Skip to the "Lead Risk" box.	<table border="1"> <tr> <td><b>Y N</b> <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?</td> <td>TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low</td> </tr> </table>	<b>Y N</b> <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
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LEAD RISK			
If you reviewed these Lead risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/>	<table border="1"> <tr> <td><b>Y N</b> <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?</td> <td>Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low</td> </tr> </table>	<b>Y N</b> <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
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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!**