



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
<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 checked="" 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"/> 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? _____</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. <input type="checkbox"/> Prescribed fluoride vitamins. <input type="checkbox"/> Brush teeth.</p> <p>Shaded items are new for the 18 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"/> 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.</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 style="width:100%"> <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>NOTE EXAM ABNORMALITIES HERE</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 style="width:100%"> <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
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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?	
MOTOR	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child walk fast or run?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Can your child walk backwards?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child walk up stairs with one hand held?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he climb into adult chairs?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he throw a ball?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he stack 3-4 blocks?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he scribble?</p>
	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child say 4-10 words with meaning?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting to say 2 word phrases?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate words?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Can s/he point to 5 body parts?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child enjoy singing songs?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he turn single pages when reading a book?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Will s/he name some pictures in a book?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit TV to less than 2 hours per day?</p>
	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child appear to know what a comb is for?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he imitate behaviors like sweeping and dusting?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is s/he starting "pretend" play?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is sharing difficult for your child? (typical at this age)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you ask your child to help pick up toys?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child give hugs and kisses?</p>

BEHAVIOR RECOMMENDATIONS	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's behavior?	
<p>If these were reviewed previously, check this box. <input type="checkbox"/></p> <p>You may skip to the "Sleep" box.</p>	
MOTOR	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is your child becoming more independent? (normal)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is your discipline consistent? (very important)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you show affection regularly?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-in frequently? (praising good behavior)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you use time-out?</p> <p>(removing attention when doing unacceptable behavior)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you set limits and choose your battles wisely?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you try to give choices whenever it is reasonable?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you occasionally say "no"?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you try to ignore tantrums? (very typical)</p>
	<p>SLEEP</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child sleep well?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you maintain a bedtime routine?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Are there night fears and awakenings? (typical)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child nap once or twice daily? (variable)</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Have you lowered the crib mattress?</p> <p><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</p> <p>Where does your child usually sleep?</p>

SAFETY AWARENESS	
<p>Please review the shaded items, which are new for the 18 month visit.</p> <p>If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.</p>	
<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor play near streets and driveways?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is your child always closely supervised in the house and car?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is the car seat in the back seat? →</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you have gates to guard the stairs?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you have window guards?</p>	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your doors locked?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Are sharp table edges protected?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?</p>

TUBERCULOSIS (TB) RISK	
<p>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.</p>	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is anyone living in your house infected with HIV?</p> <p><input checked="" type="checkbox"/> <input 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.</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?</p>

TB Risk:
 High Low

LEAD RISK	
<p>If you reviewed these Lead risks previously and believe your child is still not at risk, check this box. <input type="checkbox"/></p>	<p>Y N</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child live in or visit a house built before 1978?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is there a sibling or playmate with lead poisoning?</p> <p><input checked="" type="checkbox"/> <input 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?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?</p>

Lead Risk:
 High 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!