



Well Child Visit: 18 Months



Name: _____ DOB: _____ Date: _____

Current Medications		Drug / Food Allergies			Accompanied By					
Age □ M □ F	Ht.	Wt.	HC	HR	Resp.	Temp.	Interpreter: Y / N			
Past Medical History		Interval History			Nutrition					
Recent illness : □ Yes □ No _____ Child has dental home: □ Yes □ No Reaction to previous IMMS: □ Yes □ No _____ F/u previous concern: □ None _____		Sleep: □ NL _____ □ Bedtime routine Elimination: □ NL _____ Behavior: □ NL _____ Activity (playtime): □ NL _____			□ Milk: _____ # oz/day : _____ Fruits: □ Yes □ No ___ Vegetables: □ Yes □ No Meats: □ Yes □ No ___ Vitamins: □ Yes □ No Healthy snacks: □ Yes □ No Juice: □ Yes □ No Concerns: _____					
Social / Family History				Growth-Development						
Lives at home with: _____ Parent / child interaction: □ Yes □ No _____ Tobacco smoke exposure: □ Yes □ No _____ Parents working outside home: □ Mother □ Father Child care: □ Yes □ No Type: _____ Family / work balance: □ Yes □ No _____ WIC: □ Yes □ No _____				□ Structured developmental screening: □ NL Tool _____ □ Autism-specific screening: □ NL Tool _____ Cognitive: □ NL _____ Language: □ NL _____ • Identifies body parts; brings object from another room when asked • Uses 10-20 words; vocalizes and gestures; makes animal "sounds" Physical: □ NL _____ Social: □ NL _____ • Walks up steps; runs; stacks 2-3 blocks; uses a spoon and cup • Laughs in response to others; is spontaneous with affection						
Parental concerns: _____ _____ _____										
Physical Exam (checked □ = normal)					Abnormal Findings					
<input type="checkbox"/> General (Alert, NAD) <input type="checkbox"/> Head (No deformities, symmetric) <input type="checkbox"/> Eyes (PERRL, EOMI, + RR, cover test, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> Ears (Canals clear, TMs normal, orients to sounds, voice) <input type="checkbox"/> Nose (Mucosa NL, septum NL, patent) <input type="checkbox"/> Mouth/Throat (MMM, palate intact, lips & tongue NL, no oral lesions, no erythema) <input type="checkbox"/> Teeth (Gums NL, dentition NL, no staining, caries or white spots)					<input type="checkbox"/> Heart (No murmurs, + femoral pulses) <input type="checkbox"/> Lungs (Clear breath sounds) <input type="checkbox"/> Abdomen (Soft, non-tender) <input type="checkbox"/> Skin (No rashes, no lesions) <input type="checkbox"/> Neuro (Tone, symmetry, strength & gait NL) <input type="checkbox"/> Extremities (Full ROM, strength/tone NL, no hip dysplasia) <input type="checkbox"/> Genitalia <i>Male</i> (Penis NL: circ/uncir, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge)					
Assessment				Anticipatory Guidance						
<input type="checkbox"/> Well child <input type="checkbox"/> Normal growth and development <input type="checkbox"/> IMMS UTD <input type="checkbox"/> IMMS due _____				<input type="checkbox"/> Behavior (Limit "no", consistent discipline, temper tantrums, allow simple choices, praise positive behavior) <input type="checkbox"/> Safety (Car seats, avoid smoke exposure, burns, smoke detectors, drowning, poisoning, baby gates, supervise) <input type="checkbox"/> Nutrition (Family meals, avoid struggle over foods, health snacks, limit juice, use of cup, brush teeth) <input type="checkbox"/> Development (Self-feeding, toilet training readiness, playtime, language: read, sing, talk)						
Plan										
<input type="checkbox"/> Education handout given <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Lead screening #1 (If not previously done) <input type="checkbox"/> Dental fluoride varnish every 3-6 mos. either primary care or dental office <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> Iron Deficiency Anemia risk assessment										

Next Appointment: _____ Signature: _____ Date: _____

