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

Recent illness : □ Yes □ No _____
_____
Child has dental home: □ Yes □ No
Reaction to previous IMMS: □ Yes □ No___
F/u previous concern: □ None _____
_____

Interval History

Sleep: □ NL_____
□ Bedtime routine
Elimination: □ NL _____
Behavior: □ NL _____
Activity (playtime): □ NL _____

Nutrition

□ 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

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 _____

Growth-Development

□ Structured developmental screening: □ NL Tool_____
□ Autism-specific screening: □ NL Tool_____

Cognitive: □ NL _____
- Identifies body parts; brings object from another room when asked

Language: □ NL _____
- Uses 10-20 words; vocalizes and gestures; makes animal "sounds"

Physical: □ NL _____
- Walks up steps; runs; stacks 2-3 blocks; uses a spoon and cup

Social: □ NL _____
- Laughs in response to others; is spontaneous with affection

Parental concerns: _____
_____
_____

Physical Exam (checked □ = normal)

□ **General** (Alert, NAD)
□ **Head** (No deformities, symmetric)
□ **Eyes** (PERRL, EOMI, + RR, cover test, lids NL, conjunctivae/sclera clear)
□ **Ears** (Canals clear, TMs normal, orients to sounds, voice)
□ **Nose** (Mucosa NL, septum NL, patent)
□ **Mouth/Throat** (MMM, palate intact, lips & tongue NL, no oral lesions, no erythema)
□ **Teeth** (Gums NL, dentition NL, no staining, caries or white spots)
□ **Heart** (No murmurs, + femoral pulses)
□ **Lungs** (Clear breath sounds)
□ **Abdomen** (Soft, non-tender)
□ **Skin** (No rashes, no lesions)
□ **Neuro** (Tone, symmetry, strength & gait NL)
□ **Extremities** (Full ROM, strength/tone NL, no hip dysplasia)
□ **Genitalia**
Male (Penis NL: circ/uncir, no adhesions)
Female (Labia/clitoris NL, no discharge)

Abnormal Findings

Assessment

□ Well child
□ Normal growth and development
□ IMMS UTD
□ IMMs due _____

Anticipatory Guidance

□ **Behavior** (Limit "no", consistent discipline, temper tantrums, allow simple choices, praise positive behavior)
□ **Safety** (Car seats, avoid smoke exposure, burns, smoke detectors, drowning, poisoning, baby gates, supervise)
□ **Nutrition** (Family meals, avoid struggle over foods, health snacks, limit juice, use of cup, brush teeth)
□ **Development** (Self-feeding, toilet training readiness, playtime, language: read, sing, talk)

Plan

□ Education handout given
□ Immunizations (See immunization record)
□ Lead screening #1 (If not previously done)
□ Dental fluoride varnish every 3-6 mos. either primary care or dental office
□ Fluoride supplementation risk assessment
□ Iron Deficiency Anemia risk assessment

Next Appointment: _____ **Signature:** _____ **Date:** _____

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Name: _____ **DOB:** _____ **Date:** _____

Notes:

Next Appointment: _____ **Signature:** _____ **Date:** _____