WELL CHILD VISIT – AGE 15 MONTHS

☐ Male ☐ Female

Name: _____ ID # _____ Age: _____ DOB: _____ ☐ **IHEBAT** ☐ **120-Day IHA**

Accompanied by: ☐ Mom ☐ Dad ☐ Relative ☐ Other: _____ **Date of Visit:**_____

Wt: lbs/oz/kg (%ile)	Ht: inches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Hgb :_____ Bld Lead Level:_____ Nurse/MA_____

HISTORY

Interim History:
- ☐ No Problems
  - ☐ Significant Illness / Injury _____
  - ☐ Medications: _____
  - ☐ Allergies: _____
  - ☐ Visits to other health care provider: (name) _____

Social / Family History:
- ☐ No interval changes
  - ☐ Divorced / Single Parent
  - ☐ Child care Type:_____

Changes since last visit:_____

Nutrition: ☐ Breast ☐ Bottle ☐ Cup
Milk _____ Oz/day _____
Solid foods _____
Juice _____
Water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____
_____

Sleep: ☐ NL _____
_____

Behavior: ☐ NL _____

Toxic exposure: Lead ☐Yes ☐No Passive Smoking ☐Yes ☐ No
TB risk: ☐ High ☐ Low

DEVELOPMENTAL HISTORY (✓ if within Normal Limits)

- ☐ Says 5-15 words
- ☐ Points to 2 body parts
- ☐ Tells what he/she wants by pulling, pointing or grunting
- ☐ Understands simple commands / Points to pictures in book
- ☐ Walks well / Stoops / Climbs stairs
- ☐ Feeds self with fingers / Scribbles
- ☐ Stacks 2 blocks
- ☐ Drinks from a cup
- ☐ Listens to a story
- ☐ Gives & takes food or toys / Throws objects in play

PHYSICAL EXAM (✓ if within Normal Limits)

NL		Comment if Abnormal
☐	General Appearance	
☐	Skin	
☐	Head	
☐	Eyes / Appears to see	
☐	Ears / Appears to hear	
☐	Nose	
☐	Mouth and Throat	
☐	Teeth	
☐	Neck	
☐	Lungs	
☐	Heart	
☐	Femoral Pulses	
☐	Abdomen	
☐	Genitalia	
☐	Ext/Hips	
☐	Back (Scoliosis)	
☐	Neurologic	

ASSESSMENT

- ☐ Well Child

ANTICIPATORY GUIDANCE / EDUCATION (✓ if discussed or handout given)

- ☐ Healthy habits – adequate sleep, exercise, fluids
- ☐ Discontinue bottle, maximum amount of milk
- ☐ Safe foods, snacks, healthy food choices
- ☐ Feeds self, variable appetite
- ☐ Sleep habits
- ☐ Toilet habits
- ☐ Exploration, physical activity
- ☐ Curiosity about genitalia
- ☐ Family playtime
- ☐ Dental care, toothbrush
- ☐ Injury prevention, window guards, pets, mower, street
- ☐ Childproof home; Syrup of Ipecac, Close supervision
- ☐ Discipline, time-out, set limits
- ☐ Interactive talking, singing, reading

REFERRALS / AUTHORIZATIONS

- ☐ WIC
- ☐ CCS
- ☐ Counseling
- ☐ Specialist (name) _____
- ☐ Vision Referral
- ☐ Dental Referral

IMMUNIZATIONS / LABORATORY

- ☐ DTaP ☐ IPV ☐ VZV ☐ Hct/Hgb
- ☐ Hib ☐ MMR ☐ PCV ☐ Lead Screen
- ☐ Other: _____ ☐ _____
- ☐ Vaccine Information Statements (VIS) given to patient
- ☐ PPD Date given:_____ Results: _____
- ☐ CXR Results: _____

Plan: 1. **NEXT VISIT AT AGE 18 Months**
2.
3.

10/03

Signature_____**MD/DO/NP/PA Date**:_____