

15-18 MONTH WELL CHILD VISIT

Hirsch Holistic Family Medicine

3525 Ensign Rd NE Ste N

Olympia WA 98506

(360) 464-9965 / (800) 897-8320 fax

Patient name: _____ Date _____ Age _____

Accompanied by: _____ Birthdate _____

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

Yes No Overall, I feel confident that my child is doing well
Yes No I have enough help with my child
Who lives with you and your child? _____

No Yes Parenting is harder than I thought it would be
No Yes There have been recent changes or stresses in our family
No Yes My child attends daycare. How many days a week? _____

FEEDING

No Yes I have questions about my child's diet/nutrition
My child takes breast milk _____ times per day, or
whole milk _____ oz per day.
My child eats _____ meals per day and _____ snacks per day
No Yes My child drinks water/juice _____ oz per day.
No Yes My child has a bottle at bedtime.
No Yes I have questions about teething/tooth care _____

SLEEPING / VOIDING AND STOOLING

Yes No I am satisfied with my child's sleep schedule
naps per day _____ # hours of sleep at night _____
I get my child to sleep by: Feeding / Rocking / Pacifier / Self / Other _____
No Yes My child wakes up in the middle of the night. To get my child
back to sleep I _____
Yes No My child pees and poops normally
Wet diapers _____ Stool diapers _____ per day
No Yes I have questions about toilet training _____

BEHAVIOR AND DEVELOPMENT

No Yes I have questions about my child's development
Yes No My child points to things to show them to me
Yes No My child can say mama/dada and at least 3 other words (apx #) _____
Yes No My child walks well
Yes No My child bends over to pick things up
Yes No My child can scribble
Yes No My child likes to play pretend games
No Yes I have questions about discipline _____

PREVENTION

No Yes My child lives with someone who smokes cigarettes
No Yes My child or another person living with us was born outside the
U.S. or has traveled to Asia, Mexico, Latin America, or Africa
No Yes I have a family member who has had Tuberculosis
Yes No I always keep my child in the car seat when driving
Yes No All poisons/sharp objects are locked/out of reach in our home
Yes No Our light sockets are covered
Yes No Windows and doors are always locked
Yes No I have smoke detectors and test them often
Yes No I feel my child is safe in our home and/or at daycare
No Yes Are there any other issues you want to discuss today?

DISCUSSION TOPICS

General questions
Family support
Increasing independence
Childcare arrangements
Anticipate colds and viruses

Continue breastfeeding
Encourage table foods/self-feeding/meal time routines
Vitamin D/Iron sources
Decreased appetite
Limit juice and avoid sweets
Work on discontinuing bottles
Dental care/dentist visit

Need for bedtime routine
Avoid bottle at bedtime

Normal variation
Fiber in diet
Delay toilet training

R-PDQ if concerns

Increased vocabulary
Social games, books
Imitative behavior
Scribbling
Climbing, exploring
Temper tantrums
Discipline, time out

Risk of tobacco exposure
Assess TB risk
Correct use of car seats
Choking hazards
Pan handles turned in
No plastic bags or balloons
Poison control 800-222-1222
Water safety/drowning issues
Injuries #1 cause of death

Mortality leaders: Accidental injuries and falls, drowning, auto accidents, burns, choking

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PHYSICAL EXAM: (all items examined unless crossed out. Abnormalities circled and commented on)

Height: _____ cm (_____ %)
 Weight: _____ kg (_____ %)
 OFC: _____ cm (_____ %)
 T: _____
 P: _____
 RR: _____

General Appearance: Alert, no apparent distress, social _____
 Skin: No lesions _____
 Head/Fontanelles: Normocephalic, AF _____ x _____
 EENT: Conjunctiva clear, TMs pearly, _____
 nares clear, nl oropharynx, teeth w/o carries _____
 Cover test normal _____
 Lungs: Clear _____
 CV: normal S1, S2, RRR without murmur _____
 Normal femoral pulses _____
 Abdomen: Soft, no hepatosplenomegaly or masses _____
 Extremities: Symmetric, no deformities _____
 Hips: Negative Barlow/Ortolani, > 60° abduction _____
 Genitourinary: Male: testes descended, _____
 circumcised/uncircumcised _____
 Female: normal external genitalia _____
 Neurologic: Moves all extremities equally, _____
 normal tone _____

ASSESSMENT:	PLAN:
1. Growth and developmental progress o Normal for age o Concerns _____	_____
2. Immunizations	o Discussed recommended schedules, risks and benefits. o DtaP # _____ o Prevnar # _____ o MMR # <u>1</u> o Hep B # _____ o IPV # _____ o HIB _____ o Varicella o _____
3. Dental Health o Good o At risk o Caries	o Reviewed preventive measures o Fluoride 0.25 mg/day o ABCD referral
4. Tobacco Smoke Exposure o Yes o No	o Cessation counseling o Exposure avoidance o Referral _____
5. Screening Other: (safety, anemia, family, TB, lead, Vit D) o No risk factors identified o Risk factors _____	o Hct _____ o Lead level (if at high risk) o PPD _____ o _____ o Vit D Supplement
6. _____	6. _____
7. _____	7. _____

Next visit at 2 years
 o Problem list updated o Allergies updated
 o Med list updated o See dictated note

 Provider Signature Date Preceptor Signature