Well Child Visit: 18 Months

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

Current Medications	**Drug/Food Allergies**	**Accompanied By**

Age □M □F	**Ht.**	**Wt.**	**HC**	**Pulse**	**Resp.**	**Interpreter: Y / N**

Past Medical History

Recent illness : □ Yes □No _____
_____
Reaction to previous IMMS □ Ye □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_____

Growth-Development

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

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

Language: □ NL _____
- Uses 10-20 words; gestures; makes "sounds" of familiar animals

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

Social: □ NL _____
- Laughs in response to others; is interactive or withdrawn

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, 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

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 screen (If not done at 1-year visit)

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