# Health Maintenance Questionnaire

**18 MONTHS**

LINCOLN PEDIATRIC GROUP

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

## PARENTS' CONCERNS

List concerns you have? 1.
2.
3.
4.
5.

Please check any body areas that concern you:

| | | | |
|---|---|---|---|
| ☐Head | ☐Heart | ☐Bones | ☐Hormones |
| ☐Eyes | ☐Lungs | ☐Joints | ☐Blood |
| ☐Ears | ☐Intestines | ☐Muscles | ☐ Glands |
| ☐Nose | ☐Kidneys | ☐Brain | ☐Immunity |
| ☐Mouth | ☐Genitals | ☐Nerves | |
| ☐Throat | ☐Skin | ☐Mental Health | |

**Answer the questions below and / or check YES or NO.**

## PATIENT INFORMATION

**HISTORY**

Describe any recent injuries or illnesses:

List medications taken routinely: ☐none

Note any new stresses in the family:

Is your baby in day care? ☐No ☐Home based ☐Center based ☐Nanny
How many kids? Other:

Are there smokers in your baby's home or day care? ☐No ☐outside ☐other room

Where does your child get fluoride for their dental health?
☐city water ☐fluoride rinse / recs from dentist
☐natural fluoride in water ☐fluoride vitamin ☐no known fluoride ☐not sure

**NUTRITION**

How many ounces per day of
Whole milk: Juice:
How many servings per day of
Meat: Fruit: Veggies:

| Y | N | |
|---|---|---|
| ☐ | ☐ | Are snacks scheduled? |
| ☐ | ☐ | Is s/he starting to use a spoon and/or fork? |
| ☐ | ☐ | Does s/he drink well from a cup? |
| ☐ | ☐ | Is your child off of the bottle? If no, how many bottles per day? |

If nursing, how many times per day?

Does your child pass stools without problems? ☐Yes ☐No

- Avoid 2nd hand smoke.
- Brush teeth.

**FEEDING RECOMMENDATIONS**

- Whole milk until age 2.
- Limit juices.
- Regular family meals
- Avoid meal time battles
- Less appetite at this age.
- Avoid nuts, popcorn, hot dogs, grapes, raw carrots, frozen peas, celery, apples, raisins.
- Manners are not important yet.
- Should be off the bottle.
- Breast feeding may be weaned gently and gradually when Mom and baby are ready.

**TOILETING RECOMMENDATIONS**

- Defer toilet training until readiness signs appear (longer dry periods, dislikes soiled diaper, words).
- Purchase potty chair. Can play on it clothed.

## PHYSICAL EXAM

Ht____ Wt____ HC____ VS:_____

| | | | |
|---|---|---|---|
| Head | Nose | Lungs | Back |
| Eyes/Red reflexes | Mouth | Heart | Hips |
| Ears | Throat | Femoral pulses | Extremities |
| | Neck | Abdomen | Skin |
| | Chest | Genitalia | Neurologic |

## LAB

Hgb
Lead
PPD placed
Other:

## IMMUNIZATIONS

☐Given at Health Department
Shots up to date? ☐Yes ☐No
Any previous side effects? ☐Yes ☐No
If yes, what?

## ASSESSMENT

## PLAN

***PLEASE COMPLETE OTHER SIDE OF FORM***

Patient Name: Birth Date:

Do you have concerns about your child's vision or hearing? ☐Yes ☐No 18 month

## DEVELOPMENTAL ASSESSMENT

☐Yes ☐No Are you concerned about your child's development?

**MOTOR**

Y N
- ☐☐Does your child walk fast or run?
- ☐☐Can your child walk backwards?
- ☐☐Does your child walk up stairs with one hand held?
- ☐☐Does s/he climb into adult chairs?
- ☐☐Can s/he throw a ball?
- ☐☐Can s/he stack 3-4 blocks?
- ☐☐Does s/he scribble?

**LANGUAGE**

Y N
- ☐☐Does your child say 4-10 words with meaning?
- ☐☐Is s/he starting to say 2 word phrases?
- ☐☐Does s/he imitate words?
- ☐☐Do you repeat his/her words using proper enunciation?
- ☐☐Can s/he point to 5 body parts?
- ☐☐Does your child enjoy singing songs?
- ☐☐Will s/he turn single pages when reading a book?
- ☐☐Will s/he name some pictures in a book?
- ☐☐Do you limit TV to less than 2 hours per day?

**SOCIAL**

Y N
- ☐☐Does your child appear to know what a comb is for?
- ☐☐Does s/he imitate behaviors like sweeping and dusting?
- ☐☐Is s/he starting "pretend" play?
- ☐☐Is sharing difficult for your child? (typical at this age)
- ☐☐Do you ask your child to help pick up toys?
- ☐☐Does your child give hugs and kisses?

## BEHAVIOR RECOMMENDATIONS

☐Yes ☐No Are you concerned about your child's behavior?

If these were reviewed previously, check this box. ☐

Y N You may skip to the "Sleep" box.
- ☐☐Is your child becoming more independent? (normal)
- ☐☐Is your discipline consistent? (very important)
- ☐☐Do you show affection regularly?
- ☐☐Do you use time-in frequently? (praising good behavior)
- ☐☐Do you use time-out? (removing attention when doing unacceptable behavior)
- ☐☐Do you set limits and choose your battles wisely?
- ☐☐Do you try to give choices whenever it is reasonable?
- ☐☐Do you occasionally say "no?"
- ☐☐Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?
- ☐☐Do you try to ignore tantrums? (very typical)

**SLEEP**

Y N
- ☐☐Does your child sleep well?
- ☐☐Do you maintain a bedtime routine?
- ☐☐Are there night fears and awakenings? (typical)
- ☐☐Does your child nap once or twice daily? (variable)
- ☐☐Have you lowered the crib mattress?
- ☐☐Are you OK with your child's use of self-comforting behaviors?
  - ☐thumb sucking ☐pacifier
  - ☐favorite object? ☐None

Where does your child usually sleep?

## SAFETY AWARENESS

The shaded items are new for the 18 month visit.

Y N
- ☐☐Do you monitor play near streets and driveways?
- ☐☐Is your child always closely upervised in the house and car?
- ☐☐Is the car seat rear facing in the back seat? ➔

  Car seat is rear facing until 2 yrs old or until they reach the highest weight or height allowed by car seat's manufacturer.
- ☐☐Do you have the Poison Control center's number handy?
- ☐☐Are medications, poisons and plants out of reach?
- ☐☐Do you always monitor your child while s/he is in the bath tub?
- ☐☐Do you watch closely around lakes, wells, buckets and toilets?
- ☐☐Do you have gates to guard the stairs?
- ☐☐Do you have window guards?

Y N
- ☐☐Do you keep your doors locked?
- ☐☐Do you keep your child away from machinery/tractors/mowers?
- ☐☐Do you monitor him/her for climbing into dangerous situations?
- ☐☐Are sharp table edges protected?
- ☐☐Do you keep small items out of reach which baby could choke on?
- ☐☐Do you check toys for breakage that may be hazardous?
- ☐☐Do you keep balloons and plastic wrappers away from your child?
- ☐☐Is the water temperature in your house less than 120 degrees?
- ☐☐Do you have a fire escape plan?
- ☐☐Do you check your smoke detectors regularly?
- ☐☐Do you keep your curling iron out of reach?
- ☐☐Do you limit sun exposure?
- ☐☐Have you inserted electrical outlet covers?
- ☐☐Do you watch for frayed electrical cords in need of repair?

## Tuberculosis (TB) RISK

TB Risk: ☐High ☐Low

Y N
- ☐☐Has your child been around anyone with contagious TB or a positive PPD test?
- ☐☐Has your child had contact with people from Asia, Middle East, Africa or Latin America?
- ☐☐Is anyone living in your house infected with HIV?
- ☐☐Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers.
- ☐☐Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?

## LEAD RISK

Lead Risk: ☐High ☐Low

Y N
- ☐☐Does your child live in or visit a house built before 1978?
- ☐☐Is there a sibling or playmate with lead poisoning?
- ☐☐Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways?
- ☐☐Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?
- ☐☐Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?

*Who answered the above questions?* *Thank you for helping us help you and your child!!*

Child's Name: Date of Birth:
Person completing this form:
Relationship to Child: Today's date:

**M-CHAT**

Please fill out the following about your child's usual behavior, and try to answer every question.
If the behavior is rare, (you've only seen it once or twice), please answer as if your child does *not* do it.

| | |
|---|---|
| Yes ☐ No ☐ | 1. Does your child enjoy being swung, bounced on your knee, etc.? |
| Yes ☐ No ☐ | 2. Does your child take an interest in other children? |
| Yes ☐ No ☐ | 3. Does your child like climbing on things, such as upstairs? |
| Yes ☐ No ☐ | 4. Does your child enjoy playing peek-a-boo/hide-and-seek? |
| Yes ☐ No ☐ | 5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? |
| Yes ☐ No ☐ | 6. Does your child ever use his/her index finger to point, to ask for something? |
| Yes ☐ No ☐ | 7. Does your child ever use his/her index finger to point, to indicate interest in something? |
| Yes ☐ No ☐ | 8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them? |
| Yes ☐ No ☐ | 9. Does your child ever bring objects over to you (parent) to show you something? |
| Yes ☐ No ☐ | 10. Does your child look you in the eye for more than a second or two? |
| Yes ☐ No ☐ | 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) |
| Yes ☐ No ☐ | 12. Does your child smile in response to your face or your smile? |
| Yes ☐ No ☐ | 13. Does your child imitate you? (e.g., you make a face - will your child imitate it?) |
| Yes ☐ No ☐ | 14. Does your child respond to his/her name when you call? |
| Yes ☐ No ☐ | 15. If you point at a toy across the room, does your child look at it? |
| Yes ☐ No ☐ | 16. Does your child walk? |
| Yes ☐ No ☐ | 17. Does your child look at things you are looking at? |
| Yes ☐ No ☐ | 18. Does your child make unusual finger movements near his/her face? |
| Yes ☐ No ☐ | 19. Does your child try to attract your attention to his/her own activity? |
| Yes ☐ No ☐ | 20. Have you ever wondered if your child is deaf? |
| Yes ☐ No ☐ | 21. Does your child understand what people say? |
| Yes ☐ No ☐ | 22. Does your child sometimes stare at nothing or wander with no purpose? |
| Yes ☐ No ☐ | 23. Does your child look at your face to check your reaction when faced with something unfamiliar? |