



Health Maintenance Questionnaire

15 MONTHS

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:

- | | | | |
|---------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Heart | <input type="checkbox"/> Bones | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestines | <input type="checkbox"/> Muscles | <input type="checkbox"/> Glands |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Brain | <input type="checkbox"/> Immunity |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Genitals | <input type="checkbox"/> Nerves | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> Mental Health | |

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

PATIENT INFORMATION

H I S T O R Y	Describe any recent injuries or illnesses: _____
	List medications taken routinely: <input type="checkbox"/> none _____
	Note any new stresses in the family: _____
	Is your baby in day care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Nanny How many kids in the room/home? _____
N U T R I T I O N	Are there smokers in your baby's home or day care? <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room
	Y N <input type="checkbox"/> <input type="checkbox"/> Has baby been to a dentist yet? Dental visits are recommended within 6 months of the first tooth erupting, so 12 months old is typical. Clean teeth regularly. Never allow a bottle in bed or continuous suckling during the night, as this contributes to cavities.
	How many ounces per day of Whole milk: _____ Juice: _____ How many servings per day of Meat: _____ Fruit: _____ Veggies: _____
	Y N <input type="checkbox"/> <input type="checkbox"/> Are snacks scheduled? <input type="checkbox"/> <input type="checkbox"/> Has your child tolerated all foods introduced? <input type="checkbox"/> <input type="checkbox"/> Does your child self feed using fingers? <input type="checkbox"/> <input type="checkbox"/> Is s/he starting to use a spoon and/or fork? <input type="checkbox"/> <input type="checkbox"/> Does s/he drink well from a cup? <input type="checkbox"/> <input type="checkbox"/> Is your child off of the bottle? If no, how many bottles per day? _____
Nursing how many times per day? _____	
Does your child pass stools without problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- Avoid 2nd hand smoke.

FEEDING RECOMMENDATIONS

- Whole milk until age 2.
- Limit juices.
- 3 meals per day + snacks.
- Less appetite at this age.
- Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins.
- Manners are not important yet.
- Wean off 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		Lab/Immunizations
Ht _____	Wt _____	HC _____
VS: _____		
EXAM:		
ASSESSMENT	PLAN	

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name:

Birth Date:

15 month

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

DEVELOPMENTAL ASSESSMENT

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

M O T O R	Y N
	<input type="checkbox"/> <input type="checkbox"/> Can your child walk alone, stop, start and stoop over?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he creep up stairs?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he scribble?
L A N G U A G E	Y N
	<input type="checkbox"/> <input type="checkbox"/> Is your child saying 3 to 6 words?
	<input type="checkbox"/> <input type="checkbox"/> Do you repeat his/her words using proper enunciation?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he use jargon and/or gestures?
	<input type="checkbox"/> <input type="checkbox"/> Can your child point to 1-2 body parts?
	<input type="checkbox"/> <input type="checkbox"/> Can s/he follow 1 step commands?
	<input type="checkbox"/> <input type="checkbox"/> Will s/he listen to a story book?
	<input type="checkbox"/> <input type="checkbox"/> Will s/he point to pictures in books?
S O C I A L	Y N
	<input type="checkbox"/> <input type="checkbox"/> Does your child know proper use of objects, like placing a phone to the ear and a comb to the hair?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he imitate behaviors such as playing with dolls, and sweeping and dusting?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he indicate wants by pulling, pointing, grunting or vocalizing?
	<input type="checkbox"/> <input type="checkbox"/> Does your child give hugs?
	<input type="checkbox"/> <input type="checkbox"/> Does s/he frown when scolded?

BEHAVIOR RECOMMENDATIONS

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

If these were reviewed previously, check this box.
You may skip to the "Sleep" box.

Y N

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 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)

**S
L
E
E
P**

Y N

Does your child sleep well?

Do you maintain a bedtime routine?

Does your child nap once or twice daily? (typical)

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 15 month visit.

<p>Y N</p> <p><input type="checkbox"/><input type="checkbox"/> Do you have window guards?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you keep your doors locked?</p> <p><input type="checkbox"/><input type="checkbox"/> Is the car seat rear facing in the back seat? →</p> <p>2019 Nebraska Car Seat Law: Kids ride rear-facing until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer. Kids under 8 must ride in the back seat.</p> <p><input type="checkbox"/><input type="checkbox"/> Do you have the Poison Control center's number handy?</p> <p><input type="checkbox"/><input type="checkbox"/> Are medications, poisons and plants out of reach?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you have gates to guard the stairs?</p>	<p>Y N</p> <p><input type="checkbox"/><input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you keep small items out of reach which baby could choke on?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you check toys for breakage that may be hazardous?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child?</p> <p><input type="checkbox"/><input type="checkbox"/> Is the water temperature in your house less than 120 degrees?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you have a fire escape plan?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you check your smoke detectors regularly?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you keep your curling iron out of reach?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you limit sun exposure?</p> <p><input type="checkbox"/><input type="checkbox"/> Have you inserted electrical outlet covers?</p> <p><input type="checkbox"/><input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?</p>
---	--

Tuberculosis (TB) RISK

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?

TB Risk:
High Low

LEAD RISK

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?

Lead Risk:
High Low

Who answered the above questions?

Thank you for helping us help you and your child!!!