Health Maintenance Questionnaire

15 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?
☐	☐	Has your child tolerated all foods introduced?
☐	☐	Does your child self feed using fingers?
☐	☐	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.
- 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

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 **15 month**

DEVELOPMENTAL ASSESSMENT

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

MOTOR

Y N
☐☐Can your child walk alone, stop, start and stoop over?
☐☐Can s/he creep up stairs?
☐☐Does s/he scribble?
☐☐Can s/he stack 2 blocks?

LANGUAGE

Y N
☐☐Is your child saying 3 to 6 words?
☐☐Do you repeat his/her words using proper enunciation?
☐☐Does s/he use jargon and/or gestures?
☐☐Can your child point to 1-2 body parts?
☐☐Can s/he follow 1 step commands?
☐☐Will s/he listen to a story book?
☐☐Will s/he point to pictures in books?
☐☐Does your child enjoy singing songs?
☐☐Do you limit TV to less than 2 hours per day?

SOCIAL

Y N
☐☐Does your child know proper use of objects, like placing a phone to the ear and a comb to the hair?
☐☐Does s/he imitate behaviors such as playing with dolls, and sweeping and dusting?
☐☐Does s/he indicate wants by pulling, pointing, grunting or vocalizing?
☐☐Does your child give hugs?
☐☐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)

SLEEP

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.

Y N
☐☐Do you have window guards?
☐☐Do you keep your doors locked?
☐☐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?

Y N
☐☐Do you keep your child away from machinery/tractors/mowers?
☐☐Do you monitor him/her for climbing into dangerous situations?
☐☐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!!*