



Health Maintenance Questionnaire

18 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

HISTORY	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? _____
NUTRITION	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 12months 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"/> 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? _____
If 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.
- 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		Lab/Immunizations
Ht _____	Wt _____	HC _____
VS: _____		
EXAM:		
ASSESSMENT	PLAN	

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

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?

M O T O R	Y N
	<input type="checkbox"/> Does your child walk fast or run?
	<input type="checkbox"/> Can your child walk backwards?
	<input type="checkbox"/> Does your child walk up stairs with one hand held?
	<input type="checkbox"/> Does s/he climb into adult chairs?
L A N G U A G E	Y N
	<input type="checkbox"/> Does your child say 4-10 words with meaning?
	<input type="checkbox"/> Is s/he starting to say 2 word phrases?
	<input type="checkbox"/> Does s/he imitate words?
	<input type="checkbox"/> Do you repeat his/her words using proper enunciation?
S O C I A L	Y N
	<input type="checkbox"/> Does your child appear to know what a comb is for?
	<input type="checkbox"/> Does s/he imitate behaviors like sweeping and dusting?
	<input type="checkbox"/> Is s/he starting "pretend" play?
	<input type="checkbox"/> Is sharing difficult for your child? (typical at this age)

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)

**S
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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.

<p>Y N</p> <p><input type="checkbox"/> Do you monitor play near streets and driveways?</p> <p><input type="checkbox"/> Is your child always closely supervised in the house and car?</p> <p><input type="checkbox"/> Is the car seat rear facing in the back seat? →</p> <hr style="border-top: 1px dashed black;"/> <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> <hr style="border-top: 1px dashed black;"/> <p><input type="checkbox"/> Do you have the Poison Control center's number handy?</p> <p><input type="checkbox"/> Are medications, poisons and plants out of reach?</p> <p><input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub?</p> <p><input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?</p> <p><input type="checkbox"/> Do you have gates to guard the stairs?</p> <p><input type="checkbox"/> Do you have window guards?</p>	<p>Y N</p> <p><input type="checkbox"/> Do you keep your doors locked?</p> <p><input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers?</p> <p><input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations?</p> <p><input type="checkbox"/> Are sharp table edges protected?</p> <p><input type="checkbox"/> Do you keep small items out of reach which baby could choke on?</p> <p><input type="checkbox"/> Do you check toys for breakage that may be hazardous?</p> <p><input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child?</p> <p><input type="checkbox"/> Is the water temperature in your house less than 120 degrees?</p> <p><input type="checkbox"/> Do you have a fire escape plan?</p> <p><input type="checkbox"/> Do you check your smoke detectors regularly?</p> <p><input type="checkbox"/> Do you keep your curling iron out of reach?</p> <p><input type="checkbox"/> Do you limit sun exposure?</p> <p><input type="checkbox"/> Have you inserted electrical outlet covers?</p> <p><input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?</p>
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Tuberculosis (TB) RISK

<p>Y N</p> <p><input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test?</p> <p><input type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America?</p> <p><input type="checkbox"/> Is anyone living in your house infected with HIV?</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?</p>	<p>TB Risk:</p> <p><input type="checkbox"/>High <input type="checkbox"/>Low</p>
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LEAD RISK

<p>Y N</p> <p><input type="checkbox"/> Does your child live in or visit a house built before 1978?</p> <p><input type="checkbox"/> Is there a sibling or playmate with lead poisoning?</p> <p><input type="checkbox"/> 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?</p> <p><input type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?</p> <p><input type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?</p>	<p>Lead Risk:</p> <p><input type="checkbox"/>High <input type="checkbox"/>Low</p>
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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 <input type="checkbox"/> <input type="checkbox"/>	1. Does your child enjoy being swung, bounced on your knee, etc.?
Yes No <input type="checkbox"/> <input type="checkbox"/>	2. Does your child take an interest in other children?
Yes No <input type="checkbox"/> <input type="checkbox"/>	3. Does your child like climbing on things, such as upstairs?
Yes No <input type="checkbox"/> <input type="checkbox"/>	4. Does your child enjoy playing peek-a-boo/hide-and-seek?
Yes No <input type="checkbox"/> <input type="checkbox"/>	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 <input type="checkbox"/> <input type="checkbox"/>	6. Does your child ever use his/her index finger to point, to ask for something?
Yes No <input type="checkbox"/> <input type="checkbox"/>	7. Does your child ever use his/her index finger to point, to indicate interest in something?
Yes No <input type="checkbox"/> <input type="checkbox"/>	8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?
Yes No <input type="checkbox"/> <input type="checkbox"/>	9. Does your child ever bring objects over to you (parent) to show you something?
Yes No <input type="checkbox"/> <input type="checkbox"/>	10. Does your child look you in the eye for more than a second or two?
Yes No <input type="checkbox"/> <input type="checkbox"/>	11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)
Yes No <input type="checkbox"/> <input type="checkbox"/>	12. Does your child smile in response to your face or your smile?
Yes No <input type="checkbox"/> <input type="checkbox"/>	13. Does your child imitate you? (e.g., you make a face - will your child imitate it?)
Yes No <input type="checkbox"/> <input type="checkbox"/>	14. Does your child respond to his/her name when you call?
Yes No <input type="checkbox"/> <input type="checkbox"/>	15. If you point at a toy across the room, does your child look at it?
Yes No <input type="checkbox"/> <input type="checkbox"/>	16. Does your child walk?
Yes No <input type="checkbox"/> <input type="checkbox"/>	17. Does your child look at things you are looking at?
Yes No <input type="checkbox"/> <input type="checkbox"/>	18. Does your child make unusual finger movements near his/her face?
Yes No <input type="checkbox"/> <input type="checkbox"/>	19. Does your child try to attract your attention to his/her own activity?
Yes No <input type="checkbox"/> <input type="checkbox"/>	20. Have you ever wondered if your child is deaf?
Yes No <input type="checkbox"/> <input type="checkbox"/>	21. Does your child understand what people say?
Yes No <input type="checkbox"/> <input type="checkbox"/>	22. Does your child sometimes stare at nothing or wander with no purpose?
Yes No <input type="checkbox"/> <input type="checkbox"/>	23. Does your child look at your face to check your reaction when faced with something unfamiliar?

1999 Diana Robins, Deborah Fein, & Marianne Barton

