Well Child Care 15 months

Name : DOB: Date:

Do you have any concerns today ? □ No Yes____

Nutrition/Review of systems	yes	no	Review of systems/symptoms	yes	no
Appetite good ?			Any Vision Problems?		
Eats carbs, vegetables ,fruits, meat, fish ,fast foods, candy? (circle)			Any hearing problems?		
Breast feeding ?			Any breathing problems ?		
Drinks Milk? _________oz/day			Any heart problems ?		
Drinks soda ? _________oz/day			Any skin problems?		
Drinks juice ? _________oz/day			Any sleep concerns?		
Bowel movements normal ?			Any past bad reactions from immunizations ?		
Stool hard ? Cries with bowel movements ?			Any lead poisoning risks ?		
Urination normal?			Any TB Exposure?		
Immunizations up to date?					
Oral Health risk Assessment:					
Mother or primary caregiver has a dentist ?			Mother / primary caregiver had active tooth decay in past 12 mo		
Frequent snacking ?			Bottle/ sippy cup use with fluids other than water ?		
Special health care needs?			Child has a dentist ?		
Medicaid eligible ?			Water supply □ city □ well □ drink bottled water		
Has teeth brushed twice daily?			Any dental Concerns?		
Developmental Questions : Does your baby					
Have a vocabulary of 5-10 words ?			Understand 50 words ?		
Imitate new less familiar words?			Stack 2 objects or blocks?		
Help with getting undressed?			Hold and drink from a cup?		
Walk independently and seldom falls?			Squat to pick up toy?		
Safety/anticipatory guidance issues:					
Using car seat ? rear facing? front facing ? (circle)			Family violence & substance abuse? circle		
Fall, Fire and Burn precaution in place ?			Exposed to passive smoking?		
Medication , personal hygiene products, alcohol ,cleaning supplies ,trash containers out of reach?			Home swimming pool ?		
Family history:					
High cholesterol ,Triglycerides			Obesity		
Diabetes			Early Heart disease ,Hypertension		

Anticipatory Guidance: *□ discussed and /or handout given.*

Communication and social development: *□Give limited choices □ stranger anxiety □ read and talk with child .****Sleep routine and issues:*** *□ consistent routines □ night waking .****Tamper tantrums & Discipline:*** *□ distraction □ praise □ consistency.*

Diet & Nutrition: *□food variety including carbs, protein, fat ,fibers □ Limit fast foods and eating out □ Limit milk intake to 16 oz/day or less for children 1-5 yrs. □ Limit juice and other sweetened drinks 4-6 oz/day .* ***Healthy teeth:*** *□ first dentist visit □ healthy oral habits □ No bottle □ drink from non-covered cup (avoid sippy cups).*

Safety: *□ Use rear facing car seat until age 2 and weight 35 lbs. □ Choking hazards: foods (hot dogs, hard candy, nuts, popcorn, chunks of meat, vegetables etc) and small objects (coins, balloons, button batteries, marbles, small toys or parts etc).* ***Media use :*** *□ No TV under 2 yrs .*

Immunization: *□ Risks, benefits, side effects, alternative □ refused, vaccine refusal form signed.*

Signature of parent/guardian: **Provider Signature:**