Iowa Child Health and Development Record

15 month Well Exam

Date______________________**Patient #**____________

Name______________________**Date of Birth**__________

Address______________________________________

____

Lives with: ❑ 1 parent ❑ 2 parents ❑ Other caregiver

❑ Others (including siblings)______________________

____

May release information to: (parent, guardian, other family -- list)______________

____

Parental concerns: ____________________________

Changes in child's health since last visit:____________

____

GENERAL HEALTH:

Nutrition: ❑ Breast: ____times/day

❑ Cow's milk____oz/day

YES	NO	
❑	❑	Bottle?____times/day
❑	❑	Eats all food groups, incl. fruits and vegetables?
❑		Juice ____oz/day
❑	❑	**Daily oral health care**
❑	❑	**Has had dental visit**

Elimination: ❑ Stooling: soft, easy to pass BMs___________

Sleep:____hours through the night

YES	NO	
❑	❑	Problems? Night feedings?_________________
❑	❑	Bottle to bed?

DEVELOPMENT:

Screen or refer if concerns or "No" response on milestones in **bold type**

YES	NO	
❑	❑	**Good eye contact***
❑	❑	Imitates activities
❑	❑	**Points or gestures for needs***
❑	❑	Follow simple commands "stop" or "give me"
❑	❑	**Says at least one word besides "ma-ma" or "da-da"***
❑	❑	**Puts block in cup**
❑	❑	**Walks well without support**
❑	❑	May take step backwards

(***autism risk**)

Family concerns about development, behavior, motor or social skills:______________________________

____

MEDICAL HISTORY:

Allergies:________________Meds:________________

Major medical illnesses/Special health care needs:__________

____

Hospitalizations______________________________

Surgeries:___________________________________

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare: ______________________________________

FAMILY RISK FACTORS:

Changes in family since last visit:_______________________

____

Stress: How much stress are you and your family under now?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

What kind of stress? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ Violence/Abuse ❑ Lack of help ❑ Financial
❑ Health Insurance ❑ Child care ❑ Other ___________

How stressful is caring for your child?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless? ❑ No ❑ Sometimes ❑ **Often**

In the past month have you/partner felt little interest or pleasure in doing things? ❑ No ❑ Sometimes ❑ **Often**

ANTICIPATORY GUIDANCE: ❑ Check if discussed

FAMILY WELL-BEING:

- ❑ Discuss limits and BE CONSISTENT with all children
- ❑ Family meals are important social times
- ❑ Limit TV exposure, be aware of programming
- ❑ Partner involvement; time for self, partner, each child

BEHAVIOR:

- ❑ Expect NO impulse control this year from toddler
- ❑ Emerging independence. Let choose between two options
- ❑ Narrate actions, use simple, clear words and phrases
- ❑ Read together. Reward successes. **Positive reinforcement!** 10 positives for every negative.
- ❑ Remove temptations. Distract with alternatives. Behavior management for teaching/ protecting, not punishing
- ❑ Time out for aggressive behaviors. **No** spanking.
- ❑ Put to bed awake with comfort object. No bottle in bed.
- ❑ Brief reassurance for night waking

NUTRITION / OBESITY PREVENTION / ORAL HEALTH

- ❑ Feeds self: expect to be messy! (NO foods easy to choke on)
- ❑ Sit when eating; n**o** soft drinks; limit juice
- ❑ Obesity prevention
- ❑ Dental home established? Ensure **family** dental health.
- ❑ Brush twice daily. No bottle!

SAFETY:

- ❑ "Toddler proof" home: gates across stairways, window guards; check smoke / CO detectors; no guns.
- ❑ Do not store dangerous substances in safe-looking containers.
- ❑ Hot liquids, matches, poisons out of reach.
- ❑ Seasonal safety – sunscreen, hats, bug spray, wading pools; frostbite, emergency kit in car.
- ❑ Lower crib mattress to bottom rung.
- ❑ Poison Control Center 1-800-222-1222.
- ❑ If smoking in home: discuss quitting, limiting exposure

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PHYSICAL EXAMINATION

Vital signs: P: _______R: ________T: ________ Weight_______(_________%)

Length________(_________%) Wt/Length _________% Head circumference_________(__________%)

N Abn *Comment on abnormal findings*

❑ ❑ General appearance______________________________

❑ ❑ Behavior/interaction with family______________________________

❑ ❑ Skin______________________________

❑ ❑ Head/scalp______________________________

❑ ❑ Ears______________________________

❑ ❑ Eyes______________________________

❑ ❑ Nose______________________________

❑ ❑ Mouth/Throat ______________________________

❑ ❑ Teeth______________________________

❑ ❑ Neck ______________________________

❑ ❑ Back/Chest______________________________

❑ ❑ Lungs______________________________

❑ ❑ Heart______________________________

❑ ❑ Abdomen______________________________

❑ ❑ Genitalia______________________________

❑ ❑ Musculoskeletal______________________________

❑ ❑ Neurologic ______________________________

Results reviewed: (outside info, lab, etc.)______________________________

Impression:______________________________

____

PLAN OF CARE (see Anticipatory Guidance)

❑ **Fluoride varnish given** (if high risk, such as all Title 19 paatients)

Immunizations: ❑ Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: ❑ No ❑ Yes

See current guidelines www. immunize.org/aap

LAB: (if indicated) ❑ Hb or Hct if high risk ❑ other__________________________

Developmental Follow-up ❑ No delays ❑ Follow-up in office ❑ Referral

Referral: (if indicated)______________________________

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229

For referral of children ***birth to age 3*** with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts:______________________________

Return appointment:______________________________

Signature ______________________________ Date ________________