Iowa Child Health and Development Record — 18 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;** Developmental and Autism screening recommended

YES	NO	
❑	❑	**Good eye contact***
❑	❑	**Interested in other children***
❑	❑	**Looks at object when someone points to it***
❑	❑	**Says three words other than "ma-ma" & "da-da"***
❑	❑	**Follows one step commands without gesture***
❑	❑	**Stacks at least two blocks**
❑	❑	**Uses cup**
❑	❑	May use spoon or fork
❑	❑	**Walks well, runs**
❑	❑	May walk upstairs

(***autism risk**)

Family concerns about speech, learning, behavior, social or motor skills:_____

MEDICAL HISTORY:

Medications:_____Allergies:_____

Major medical illnesses:_____

_____

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:

- ❑ Short family outings. Both parents spend time w/ each child.
- ❑ Allow older children their own space and toys, time with parents
- ❑ Monitor TV time and programming
- ❑ Acknowledge sibling conflict, try not to take sides. Don't allow aggressive behaviors

BEHAVIOR:

- ❑ Set consistent limits. Brief timeouts, simple statements, no discussion.
- ❑ **Praise** good behavior
- ❑ Talk/sing/read to child. Ask child questions. No TV, videos.
- ❑ Support bilingual language usage.
- ❑ Toilet training - Start only when child is ready (dry for 2 hrs, knows wet and dry, pulls pants up & down.) Key is patience and child comfort – must have soft BMs; use same routine each day.
- ❑ Enjoys playing with other kids.

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Encourage feeding self and using cup- expect to be messy! Sit when eating. Obesity prevention
- ❑ May become picky in food preferences – repeatedly offer new healthy foods, let child choose.
- ❑ No soft drinks. Limit juice.
- ❑ No bottle, especially in bed.
- ❑ Brush with small (< pea) amount of fluoride toothpaste.

SAFETY:

- ❑ Car seat always in back seat. Never leave alone in car.
- ❑ Constant supervision in home and car, near water.
- ❑ Child will climb, pull cords and tablecloths, and get into unsecured cabinets/bags. Keep medicines and cleaning products high and locked
- ❑ Protect from hot liquids, surfaces (space heaters, irons, curling irons, grills), matches, guns
- ❑ Poison Control 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 _____

❑ ❑ Developmental Screening (ASQ, other)_____ ❑ ❑ Autism Screening (M-CHAT, other)_____

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

Impression:_____

_____

PLAN OF CARE (see Anticipatory Guidance)

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

Immunizations: ❑ Vaccine Information Statements offered to parent
Past adverse reactions to immunizations: ❑ No ❑ Yes
See current guidelines www. immunize.org/aap

LAB: ❑ Lead if high risk ❑ Hb or Hct if high risk ❑ other if indicated_____

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 _____