

Well Child Exam

Young Toddlers: 15-18 Months



15-18 months

Date									
Patient Name				DOB		Sex		Parent Name	
Allergies					Current Medications				
Prenatal / Family History							Ethnicity		
Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

Interval History
(include injury/illness, visits to other health care providers, changes in family or home) _____ _____
Nutrition
<input type="checkbox"/> Whole milk, cup only <input type="checkbox"/> Solids _____ servings per day <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Fluoride Rx
Elimination
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep
<input type="checkbox"/> Normal (8-12 hours) <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page
Screening
Hearing <input type="checkbox"/> Responds to voice & noise (parent report) <input type="checkbox"/> Responds to noisemaker (optional) <input type="checkbox"/> Parental observation/concerns
Vision <input type="checkbox"/> Can see small objects <input type="checkbox"/> Parental observation/concerns
Lead Poisoning Test date _____ <input type="checkbox"/> Lead level _____ mcg/dl (required for Medicaid) If Risk: <input type="checkbox"/> IPPD _____ (result) <input type="checkbox"/> Hct or Hgb _____ (result)
Immunizations
<input type="checkbox"/> Immunizations Reviewed, Given, & Charted – if not given, document rationale <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB <input type="checkbox"/> Hib <input type="checkbox"/> PCV <input type="checkbox"/> MMR <input type="checkbox"/> Varicella or Chicken Pox Date: _____ <input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours
WIC <input type="checkbox"/> Y <input type="checkbox"/> N
Developmental Questions and Observations on Page 2
Next Well Check: 24 months of age
Provider Signature:

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N		
Review of Symptoms	Physical Exam	Systems
N A	N A	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	General appearance
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Head/fontanel
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Eyes
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Ears
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Nose
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Oropharynx
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Gums/palate
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Neck
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Lungs
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Heart/pulses
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Abdomen
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Genitalia
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Spine
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Extremities/hips
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Neurological
<input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page		
Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N		
Plan		
<input type="checkbox"/> History/Problem List/Meds Updated		
<input type="checkbox"/> Referrals		
<input type="checkbox"/> WIC <input type="checkbox"/> Early On <input type="checkbox"/> Transportation		
<input type="checkbox"/> Children Special Health Care Needs		
<input type="checkbox"/> Priority Health Case Mgmt 800 998-1037		
<input type="checkbox"/> Other _____		

Anticipatory Guidance / Health Education (✓ if discussed)
Healthy and Safe Habits
Injury and Illness Prevention
<input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Keep Poison Control number handy <input type="checkbox"/> Appropriate car seat placed in back seat <input type="checkbox"/> Pool/tub/water safety <input type="checkbox"/> Use stair gates, safety locks, window guards <input type="checkbox"/> Childproof home (window guards, cleaners, medicines, outlets, guns, dangling cords) <input type="checkbox"/> Supervise near mowers, driveways, streets <input type="checkbox"/> Never leave child alone in home or car <input type="checkbox"/> Turn pot handles to back of stove <input type="checkbox"/> Limit time in sun, use hat/sunscreen <input type="checkbox"/> Check home for lead poisoning hazards <input type="checkbox"/> Avoid or limit TV viewing
Nutrition
<input type="checkbox"/> Encourage child to feed self drink from cup <input type="checkbox"/> Eat meals as a family <input type="checkbox"/> Avoid choke foods, limit sugar <input type="checkbox"/> Let toddler decide what/how much to eat <input type="checkbox"/> Don't use food to comfort or reward
Oral Health
<input type="checkbox"/> Don't put toddler to bed with bottle <input type="checkbox"/> Brush toddler's teeth w/soft toothbrush/water
Social Competence
<input type="checkbox"/> Set specific limits, be consistent <input type="checkbox"/> Delay toilet training <input type="checkbox"/> Interactive talking, singing, and reading <input type="checkbox"/> Expect curiosity about genitals <input type="checkbox"/> Daily and bedtime routine <input type="checkbox"/> Encourage self-expression, choices <input type="checkbox"/> Praise good behavior and accomplishments <input type="checkbox"/> Use discipline to teach, not punish <input type="checkbox"/> Develop strategies for nightmares
Family Support and Relationships
<input type="checkbox"/> Keep family outings short and simple <input type="checkbox"/> Allow older children their own space/ toys <input type="checkbox"/> Listen to, show interest in, respect toddler <input type="checkbox"/> Help child express emotions <input type="checkbox"/> Substance abuse, domestic violence, depression <input type="checkbox"/> Hold and cuddle child, show family affection
Community Interaction
<input type="checkbox"/> Early intervention programs if needed <input type="checkbox"/> Discuss community programs <input type="checkbox"/> Discuss child care arrangements

Date	Patient Name	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the toddler:

- Yes No
- Please tell me any concerns about the way your toddler is behaving or developing:
-
- My toddler likes to be with me.
- My toddler is interested in people, places, and things.
- My toddler shows different feelings.
- My toddler feeds self with fingers/spoon and drinks from a cup.
- My toddler can stack 2-3 blocks.

Ask the parent to respond to the following statements:

- Yes No
- I am sad more often than I am happy.
- I have people who help me when I get frustrated with my toddler.
- I am enjoying my time with my toddler.
- I have time for myself, partner, and friends.
- I feel safe with my partner.

Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Toddler Development			Parent Development		
Understands simple commands	Yes	No	Appropriately disciplines toddler	Yes	No
Walks well, stoops	Yes	No	Positively talks, listens, and responds to toddler	Yes	No
Says 3-10 words	Yes	No	Parent is loving toward toddler	Yes	No
Indicates wants by pointing or gestures.	Yes	No	Uses words to tell toddler what is coming next	Yes	No
Is able to transition from one activity to another throughout the day	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. <i>(Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents)</i>		
Appears to have a secure and attached relationship with parent	Yes	No			

Additional notes from pages 1 and 2:

Family History Update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who _____ what age _____
- New medical diagnosis: who _____ what age _____
- Anything else in your family history you have concerns or questions with: (Refer to Family History form)

Staff Signature: _____ **Provider Signature:** _____

This HME form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Association of Health Plans, and Michigan Association of Local Public Health. Adapted with permission by Priority Health 9/06.

Patient Education:

Your Toddler's Health at 15-18 months

Milestones: Ways your toddler is developing between 18 and 24 months

- Says phrases of at least two words
- Plays beside other children, stacks five or six blocks
- Is curious and likes to explore people, places, and things
- Protests and says, "NO!"
- Kicks and throws a ball
- Imitates adults, follows two-step directions
- Kisses and shows affection
- Tries to make straight lines and circles with a crayon

Safety Tips

- Falls often cause young children to get hurt. Take your child to a safe playground. Find one that has padding, sand, or wood chips under the toys. Look for small toys that fit a toddler. Stay close to your child while he/she is playing.
- Your child may try to get out of their car seat. Avoid letting him/her get out, because then he/she will try again and again.
- If he/she tries, be firm, stop the car, and refuse to move until he/she stays buckled in.
- Take soft toys, picture books, and music to entertain your child in the car.
- Wear your own seat belt, too.

Health Tips

- Your child's check-ups will be spaced farther apart as he/she gets older. If you have concerns between checkups, be sure to call the doctor or nurse and ask questions.
- Check to make sure your toddler has had all the "shots" he/she needs. If your child has missed some "shots," make an appointment to get them soon. Your child needs all of the required "shots" to have the best protection against serious diseases.
- Your child's appetite may be less than in the past. Offer a variety of healthy foods. Let him/her decide how much of each food to eat. Do not force him/her to finish food.
- Your child needs two cups of milk or yogurt, or three slices of cheese each day. Avoid low-fat foods until age 2.
- Each child develops in his or her own way, but you know your child best. If you think he/she is not developing well, you can get a free screening. Call your child's doctor or nurse if you have questions.

Parenting Tips

- Name toddler's feelings out loud – happy, sad, or mad. Use words to tell toddler what is coming next. Your toddler can understand more words than he/she can say. Give toddler simple choices. Example "squash or peas?"
- Calmly, set limits to keep toddler safe by giving your toddler something different to do. Praise your toddler when he/she does things that you like.
- When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:
 - o Make sure your child is in a safe place (like a crib) and walk away.
 - o Call a good friend to talk about what you are feeling.
 - o Call the Parent Helpline at 800 942-4357 (in Michigan). It's free! They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

For Help or More Information

Priority Health

Customer Service 616 942-1221 or 800 446-5674
Medicaid 888 975-8102
Behavioral Health 616 464-8500 or 800 673-8043
priorityhealth.com

Depression

Surrounding pregnancy and childbirth
www.depressionafterdelivery.com/Home.asp

Domestic Violence

National Domestic Violence Hotline
800 799-SAFE (7233)

Health and Nutrition Program

Women, Infant, and Children (WIC) Program,
800 262-4784

The National Women's Health Information Center Breastfeeding

Helpline 800 994-WOMAN (9662)
www.4woman.gov/breastfeeding

LA LECHE League 847 519-7730
www.lalecheleague.org

Special Health Care Needs

Children Special Health Care Services,
MDCH Family 800 359-3722

Childhood Development

Early On Michigan 800 327-5966
Michigan Head Start Association 517 374-6472

Parenting Skills or Support

Parents Hotline 800 942-4357
Family Support Network of Michigan 800 359-3722

Childcare

Child Care Licensing Agency, Michigan Department
of Consumer & Industry Services
517 373-8300

Childhood Immunizations

National Immunization Program Hotlines
800 232-2522 (English) or 800 232-0233 (Spanish)

Lead Screening

Michigan Department of Community Health Hotline
800 648-6942

Prevention of Unintentional Childhood Injuries

National Safe Kids Campaign 202 662-0600
www.safekids.org

Car Seat Safety

Auto Safety Hotline 888 327-4236

Poison Prevention

Call the Poison Control Center
800 222-1222