

PEDIATRIC VISIT 15 to 17 MONTHS

DATE OF SERVICE _____

NAME _____

DATE OF BIRTH _____ AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ %

TEMP _____

HISTORY REVIEW/UPDATE: *(note changes)*

Family health history _____

Medical history _____

Reaction to immunizations?

PSYCHOSOCIAL ASSESSMENT:

Sleep:

Recent changes in family?: *(circle all that apply)*

New members, separation, chronic illness, death, recent move,
Loss of job, other _____

Child care:

Violence Assessment:

History of injuries, accidents?

Evidence of neglect or abuse?

RISK ASSESSMENT: TB

LEAD

(Circle)

Pos/Neg

Pos/Neg

PHYSICAL EXAMINATION

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose/Mouth/Dental
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<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"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	_____

NUTRITIONAL ASSESSMENT:

Typical diet:

Education: Only water in bedtime bottle _____ Phase out bottle,
pacifier _____ Strong dislike for certain foods _____
Keep offering new foods _____

DEVELOPMENTAL ASSESSMENT:

(O=Observe, R=Report)

Social: Imitates affection _____ Helps with simple tasks _____

Imitates housework _____

Fine Motor: Scribbles spontaneously _____ Uses cup _____

Tower of 2 cubes _____ Feeds self _____

Language: 3 words other than Dada/Mama _____ Points to 1-3

named body parts _____ Understands simple

commands _____ Immature babbling _____

Gross Motor: Crawls up steps _____ Stoops and recovers _____

Walks well _____ Walks backward _____ Removes

garment _____

ANTICIPATORY GUIDANCE:

Social: Child is egocentric _____ Loves attention _____ Seeks to
control others _____

Parenting: Child may bite, hit _____ Use time out _____ Temper
tantrums: ignore, distract _____ Dependence vs autonomy
needs _____ Discipline is teaching _____ Avoid
spanking/slapping _____

Play and communication: Climbing, dancing, riding toys _____

Likes to push/pull, empty/fill, open/close _____ Enjoys

household articles _____ Read stories _____

Health: Regression during illness/stress _____ Proper shoes _____

Teeth brushing _____ Fluoride if well water _____ Second

hand smoke _____ Use sunscreen _____

Injury prevention: Infant car seat _____ Rear riding seat _____

Smoke detector/escape plan _____ Hot liquids _____

Hot water temp. _____ Poison control no. _____

Choking/suffocation _____ Firearms (owner risk/safe

storage) _____ Fall prevention (heights) _____ Water

safety (tub, pool) _____ Baby proof home _____ Don't leave

unattended _____

PLANS

1. Immunizations by schedule
2. Review lead and HCT results; obtain if not available.
3. PPD, if risk assessment positive
4. Return visit _____

Signatures _____