

PEDIATRIC VISIT 15 to 17 MONTHS

DATE OF SERVICE _____

NAME _____ M / F DATE OF BIRTH _____ AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ % HC _____ / _____ % TEMP _____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____

Family health history updated? _____

Reactions to immunizations? Yes / No _____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: _____ Child care: _____

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

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

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	<i>(describe abnormalities)</i>
<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
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Dental/Number of teeth
<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 <i>(gross assessment)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing <i>(gross assessment)</i>

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods):*

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

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: PEDs Other: *(specify)* _____

Results: Wnl Areas of Concern: _____

Referred: Yes / No Where? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Imitates affection Helps with simple tasks
Imitates housework

Fine Motor: Scribbles spontaneously Uses cup Feeds self
Tower of 2 cubes

Language: 3 words other than Dada/Mama Immature babbling
Points to 1-3 named body parts Understands simple commands

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 Avoid spanking/slapping
Discipline is teaching Dependence verses autonomy needs

Play and communication: Climbing, dancing, riding toys
Likes to push/pull, empty/fill, open/close Read stories
Enjoys household articles

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
Baby proof home Hot liquids Hot water set at 120°
Water safety (tub/pool) Choking/suffocation Poison control #
Firearms (owner risk/safe storage) Fall prevention (heights)
Don't leave unattended Smoke detector/escape plan

PLANS/ORDERS/REFERRALS

1. Immunizations ordered _____
2. Review lead and HCT results _____
3. Refer for lead and HCT testing if not available _____
4. PPD, if positive risk assessment _____
5. Fluoride Varnish Applied? Yes / No _____
6. Next preventive appointment at 18 months _____
7. Referrals for identified problems? *(specify)* _____

Signatures: _____