

PEDIATRIC VISIT 18 to 23 MONTHS

DATE OF SERVICE _____

NAME _____

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	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<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/Dentition (# of teeth)
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:

Typical diet:

Education: Prolonged mealtime with playing

Likes and dislikes change often Food jags okay

Allow self-feeding Eat with family

DEVELOPMENTAL SCREENING: (With Standardized Tool)

REQUIRED

ASQ: PEDs Other: (specify) _____

Results: Wnl Areas of Concern: _____

Referred: Yes / No Where? _____

MCHAT Required

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Removes clothes Helps with simple tasks

Imitates housework

Fine Motor: Scribbles Tower of 3-4 cubes Turns pages

Language: Combines 2 words Points to 2-4 named body parts

Follows directions Names picture (cat, bird, horse, dog, person)

Uses 10-15 words

Gross Motor: Kicks ball Throws ball Walks up steps

Walks backward

ANTICIPATORY GUIDANCE:

Social: Needs to be independent Stubbornness is normal

Does not share well

Parenting: Daily routines meet security needs

Child constantly tests parent, self, siblings, environment

"Time out" for hitting/biting Avoid spanking, slapping

Forgets rules quickly, needs reminding Give choices

Play and communication: Uses objects for imaginary play

Manipulative toys (play dough, sand, paint) Read stories

Thumb sucking and masturbation common

Favorite toy, transitional object

Health: May be toilet ready Brush teeth Fluoride if well water

Second hand smoke Use sunscreen

Injury prevention: Infant car seat Rear riding seat

Hot liquids Hot water set at 120° Water safety (tub, pool)

Poison control no. Choking/suffocation Baby proof home

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 Refer for testing if none _____
3. PPD, if risk assessment positive _____
4. Fluoride Varnish Applied? Yes / No
5. Dental visit advised or date of last dental visit _____
6. Next preventive appointment at 2 Years _____
7. Referrals for identified problems: (specify) _____

Signatures: _____