15 Month Well Exam

meridianhealth
A WellCare Company

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:________________

____

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

- ☐ Discuss limits and BE CONSISTENT with all children
- ☐ Family meals are important social times
- ☐ Limit TV exposure, be aware of programming
- ☐ Partner involvement; time for self, partner, each child

BEHAVIOR:

- ☐ Expect NO impulse control this year from toddler
- ☐ Emerging indepence. Let choose between two options
- ☐ Narrate actions, use simple, clear words and phrases
- ☐ Read together. Reward successes. Positive reinforcement! 10 positives for every negative
- ☐ Remove temptations. Distract with alternatives. Behavior management for teaching/protecting, not punishing
- ☐ Time out for aggressive behaviors. **NO spanking**
- ☐ Put to bed awake with comfort object. No bottles in bed
- ☐ Brief reassurance for night waking

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Feeds self: expect to be messy! (NO foods easy to choke on)
- ☐ Sit when eating; **NO** soft drinks; limit juice
- ☐ Obesity prevention
- ☐ Dental home established? Ensure **family** dental health
- ☐ Brush twice daily. No bottle!

SAFETY:

- ☐ "Toddler proof" home: gates across stairways, window guards, check smoke/CO detectors, no guns
- ☐ Do not store dangerous substances in safe-looking containers
- ☐ Hot liquids, matches, poisons out of reach
- ☐ Seasonal safety - sunscreen, hats, bug spray, wading pools, frostbite, emergency kit in car
- ☐ Lower crib in mattress to bottom rung
- ☐ Poison control center: **800-222-1222**
- ☐ If smoking in home: discuss quitting, limiting exposure

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care: ________________________________

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?
☐ Relationship ☐ Alcohol ☐ Drugs
☐ 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**

GENERAL HEALTH

Nutrition: ☐ Breast:_____times/day
☐ Cow's milk:_____ oz/day

YES	NO	
☐	☐	Bottle?______times/day
☐	☐	Juice: _______oz/day
☐	☐	Eats all food groups, including fruits and vegetables?
☐	☐	**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)**

YES	NO	
☐	☐	**Good eye contact***
☐	☐	Imitates activities
☐	☐	**Points or gestures for needs***
☐	☐	Follow simple commands such as "stop" or "give me"
☐	☐	**Says at least one word besides "ma-ma" or "da-da"***
☐	☐	**Puts block in cup**
☐	☐	**Walks well without support**
☐	☐	May take step backwards

(*autism risk)

Family concerns about growth, development, behavior, motor or social skills:

____

____

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MEDICAL HISTORY

Name ____________________ Date of Birth ____________________

Allergies ____________________ Medications ____________________

Major medical illnesses/special healthcare needs ____________________

Hospitalizations/Surgeries ____________________

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:______R:______T:______Weight:______(______%)

Length ______(______%) Wt/Length______% Head circumference______(______%)

Review of Systems

N	Abn	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	____________________
☐	☐	☐	☐	Neurological	____________________

Results reviewed (outside info, lab, etc.) ____________________

Impression ____________________

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused ____________________

Lab (if indicated) ____________________

☐ **Fluoride varnish given**

Developmental follow-up ☐ No delays ☐ Follow-up in office ☐ Referral

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) ____________________

Handouts ____________________

Return appointment ____________________

Signature ____________________ Date ____________________

Revised June 2012