# 18 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:

- ☐ Short family outings. Both parents spend time with each child
- ☐ Allow older children own space and toys, time with parents
- ☐ Monitor TV time and programming
- ☐ Acknowledge sibling conflict, try not to take sides. Don't allow aggressive behaviors

BEHAVIOR:

- ☐ Set consistent limits. Brief timeouts, simple statements, no discussion
- ☐ **Praise** good behavior
- ☐ Talk/sing/read to child. Ask child questions. No TV, videos
- ☐ Support bilingual language usage
- ☐ Toilet training - start only when child is ready (dry for 2 hours, knows wet and dry, pulls pants up and down). Key is patience and child comfort - must have soft BMs. Use same routine every day
- ☐ Enjoys playing with other kids

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

- ☐ Encourage feeding self and using cup - expect to be messy! Sit when eating. Obesity prevention
- ☐ May become picky in food preferences - repeatedly offer new healthy foods, let child choose
- ☐ No soft drinks. Limit juice. No bottle, especially in bed
- ☐ Brush with small (< pea) amount of fluoride toothpaste

SAFETY:

- ☐ Car seat always in back seat. Never leave alone in car
- ☐ Constant supervision in home and car, near water
- ☐ Child will climb, pull cords and tablecloths and get into unsecured cabinets/bags. Keep medicines and cleaning products high and locked
- ☐ Protect from hot liquids, surfaces (space heaters, irons, curling irons, grills), matches, guns
- ☐ 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*** |
| ☐ | ☐ | **Interested in other children*** |
| ☐ | ☐ | **Looks at objects when someone points to it*** |
| ☐ | ☐ | **Says three words other than "ma-ma" and "da-da"*** |
| ☐ | ☐ | **Follows one step commands without gesture*** |
| ☐ | ☐ | **Stacks at least two blocks** |
| ☐ | ☐ | **Uses cup** **(*autism risk)** |
| ☐ | ☐ | May use spoon or fork |
| ☐ | ☐ | **Walks well, runs** |
| ☐ | ☐ | May walk upstairs |

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 | |
| ☐ | ☐ | ☐ | ☐ | Autism screening (M-CHAT, other) | |

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**

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

**Medical referral** (if indicated) _____

**Handouts** _____

**Return appointment** _____

Signature _____ Date _____

Revised June 2012