VACCINES: P C

WELL CHILD 15 MONTHS

Today's Date:_____

Patient Name:_____ Date of Birth:_____

FAMILY HISTORY:
Changes in household since last visit ___Yes/No Explain_____
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent ___Other_____
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare ___Other_____

NUTRITION:
1. Does your child have any recurrent problems with development, special diet, weight gain/loss, refusal of any food group, stomach problems or anemia? ___Yes/No (circle any that apply, explain below)
   List: _____
2. Usual number of servings per day: 1,2,3
   ___Dairy ___Formula ___Breast ___Vegetables ___Fruits
   ___Bread, cereal, rice and pasta
   ___Meat, poultry, fish, eggs and dry beans

CHILD HEALTH: Indicate Yes or No and Check ☑ any that apply.
1. Does your child have any food or drug allergies? ___ Yes/No List_____
2. Has your child had any major illness, surgeries, injuries or hospitalizations? _____Yes/No
   List:_____
3. Does your child have any physical problems? ____Yes/No ___Low Weight Gain ___Weight Loss ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other_____
4. Does your child take any medications regularly? _____Yes/No _____
5. Has your child seen a dentist or scheduled for a dental appointment? _____Yes/No

IMMUNIZATIONS: Check ☑ Yes or No
___**Yes** ___**NO** Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY: Indicate Yes or No
Vision Screen:
1. Does your child seem to see well? _____Yes/No
2. Do your child's eyes appear to cross, drift or seem lazy? ___Yes/No Explain_____
3. Do your child's eyes appear unusual? ___Yes/No Explain_____

Hearing Screen:
1. Does your child give you toys or objects when you ask for them without using a gesture? _____Yes/No
2. Does your child point to familiar objects when asked? _____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Waves bye-bye _____Yes/No
2. Is interested in all sounds around him _____Yes/No
3. Puts block in cup _____Yes/No
4. Uses vocalization to request objects and direct attention _____Yes/No
5. Stoops and recovers _____Yes/No

MENTAL HEALTH: Check ☑ any that apply.
Feelings: ___Appropriate for age ___Cries Excessively ___Cries too little ___Angry ___Sad ___ Fearful ___ Sullen ___Anxious
Social Interaction: ___*Appropriate for age* ___Withdrawn ___Clings excessively
Thinking: ___*Appropriate for age* ___ Problems Concentrating ___Distracted ___Mistrustful
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ____Yes/No
Explain: _____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check here ☐ if no problems noted.
Skin: ___rashes ___infections
Eyes: ___Eye Discharge ___Deviation ___Excessive Tearing ___Wandering eye movement
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge ___Sore throat
Cardio: ___History of murmur
Respiratory: ___Trouble Breathing ___Wheezing
Gastrointestinal: ___Frequent Bowel Movements ____Vomiting
Genitourinary: ____Abnormal Appearance
Neuromuscular: ____Seizures ____uncoordinated movements ____gait
Musculoskeletal: ____Fractures ____Deformity

Form Complete:_____(staff initials)

WELL CHILD 15 MONTHS

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Weight:_____ Height:_____ OFC:_____ Temp:_____

FOR OFFICE USE ONLY

PHYSICAL EXAM:	**Normal**	**Abnormal**	**Comments**
Appearance	_____	_____	_____
Head/fontanels	_____	_____	_____
Skin/nodes	_____	_____	_____
Eyes	_____	_____	_____
1. Symmetric Corneal light reflex	_____ Yes/No		
2. Conjugate gaze bilaterally	_____ Yes/No		
3. Red Reflex present bilaterally	_____ Yes/No		
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth/Throat	_____	_____	_____
Teeth	_____	_____	_____
Neck	_____	_____	_____
Chest/breasts	_____	_____	_____
Heart/Pulses	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia/anus	_____	_____	_____
Spine/Hips	_____	_____	_____
Extremities	_____	_____	_____
Muscle Tone	_____	_____	_____
DTRs	_____	_____	_____

ASSESSMENT:

1. Well Child 15 Months _____ **2.**_____

3. _____**4.**_____

PLAN: ___Up to Date on Vaccinations.

Catch up Immunizations: ___Hep B # 3 ___Hib # 4 ___IPV # 3 ___ MMR # 1 ___Prevnar # 4 ___Varicella ___PPD ___DTaP #4 ___Hiberix (Hib+Tetanus Toxoid)

___Parent declines vaccinations (List)_____

Lab: ___**Lead (12 month catchup)** ___**Hct/Hgb (12 month catch up)**

___ Hep C (if 12 months old or older and born to HCV infected woman)_____

Referral made to : _____

Dental: Parent advised to make Preventive Dental Appointment:_____

Health Education Handout Given to Parent/Guardian _____

EPSDT Questionnaires: _____**Lead questionnaire given** _____**TB questionnaire given**

RTC in : _____months/prn _____yr/prn

Document in Document1 3/30/06, 2/27/09, 9/17/09, 9/23/09, 4/11, 4/30/12