13 Months–2 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit

Child lives with:

_____ Mother ____ Father ____ Stepparent _____ Grandparent

_____ Other

Total adults living in home: ______________________________

Total children living in home:______________________________

Primary caretaker for this child: ___________________________

Relationship:____

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: _____P ____ F

Type of Developmental Screen:

Standardized Parent Questionnaire:___________________________

Standardized Observational Screen: __________________________

Other: ____

Further assessment needed: _____Y ____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems
or parent concerns: _____Y _____N

Explain:

Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care:

Physical Examination

Temp _________ Pulse ____________Resp ____________

FOC__________ Height ___________Weight___________

(%)__________ (%) ______________(%)______________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				**Neurologic:**
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts				

Additional documentation:

Client Information

Name: ____

DOB: _______ /_______/ ______ Age: __________Sex: __________

SSN/Record No.: ____

Race/Ethnicity: ____

Informant/Relationship: _____________________________________

Medical Home: ____

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental* _____Y _____N

**If answered yes, further assessment needed.*

Usual Servings Per Day:

____Dairy __ Formula ___Breast ___Vegetables WIC: ___Y __N

____Breads, cereal, rice, and pasta

____Meat, poultry, fish, eggs, and dry beans

____Fruits

Sensory

Vision Screen: _____Normal _____ Abnormal

Hearing Screen: _____Normal _____ Abnormal

Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention

____Car safety restraints
____Choking, unsafe toys
____Poisoning
____Burns
____Water safety/temp
____Supervised play
____Electrical injury
____Passive smoking

Behavior

____Parent/infant interaction
____Social interaction
____Limit TV
____Set limits
____Sibling rivalry
____Toilet training

Health Promotion

____Immunizations
____Smoking in home
____Well-child care
____Dental care, appointment
____Family planning
____Daycare

Nutrition

____Healthy diet/snacks
____Iron-rich foods
____Physical activity
____Weaning
____Off bottle by age 1

Assessment

Plan

Dental referral made: ___Y ___ N

WIC: ____Referred ___ Refused ___ N/A

Immunizations: ____Up to date ___ To be given today ___ Deferred

Explain:

Lab:

Hct/Hgb ______ Lead_____________

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

Next appointment:

Date: ________________Signature/Title: __________________________________Signature/Title_______________________________________

13 Months–2 Years

If used for documentation:____________________
Patient's Name: ____________________
Date: ____________________

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.
Feelings: Angry, sad, fearful, sullen, anxious, cries excessively or too little
Behavior: Overactivity, listlessness, harms others, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

15 Months
Waves bye-bye
Is interested in all sounds around him
Puts block in cup
Uses vocalization to request objects and direct attention
Stoops and recovers

18 Months
Brings you item when asked (no pointing)
Says six words
Asks for familiar toys that are not around
Responds to "give me"
Walks backwards

2 Years
Uses spoon
Builds tower of 2 cubes
Combines 2 words
Follows 2-part directions
Kicks ball forward

Progress Notes