



PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Questions for 18 month visit

Please complete the following questions as they apply to your child.

### NUTRITION

**What is your child drinking from?**

- a cup (sippy or open) only  
 a cup (sippy or open) mostly and a bottle occasionally  
 a bottle mostly and a cup (sippy or open) occasionally  
 a bottle only

**Are you breast feeding?**  yes  no

**Is your child drinking milk?**  yes  no

If yes, what type?

- whole  1%  2%  skim  soy  rice  formula

**How much milk (or formula) does your child drink per day?**

- < 8 oz  8 to < 16 oz  16 to 24 oz  24 to 32 oz  > 32 oz

**How much juice does your child drink per day?**

- 0 to 4 oz  4 to 8 oz  8 to 16 oz  > 16 oz

**How much water does your child drink per day?**

- < 8 oz  8 to 16 oz  16 to 24 oz  > 24 oz

**Your child has what type of water source?**

- city  well  bottled with fluoride  bottled without fluoride

**What is your child eating?**

- all table foods  mostly table foods and some baby foods  
 mostly baby foods and some table foods  baby foods without any table foods

**How many scheduled meals is your child offered per day?**

- 1 to 2  2 to 3  3 to 4  > 4

**How many snacks is your child offered per day?**

- none  1  1 to 2  >2

**Has your child eliminated any main food groups from his/her diet?**

- meats  vegetables  fruits  grains/breads

### ELIMINATION

**How frequent does your child have a bowel movement?**

- > every 4 days  every 3 to 4 days  every other day  every day  1 to 2 times per day  > 2 times per day

**Is your child having any problems with his/her bowel movements? yes/no**

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SLEEP

Does your child have a transitional object for sleep?  yes  no

Does your child have a fairly consistent bedtime?  yes  no

Is your child using a pacifier to fall asleep?  yes  no

Where does your child fall asleep?

in his/her own room  in a room with a sibling  in his/her parents room  elsewhere

How many hours does your child sleep at night?

< 8  8 to 10  10 to 12  > 12

How many naps does your child take during the day?

none  1  2  > 2

Does your child have any problems with his/her sleep?

snoring  restless sleep  paused or startled breathing  difficulty falling asleep  night terrors  
 poor sleep quality (being tired after sleeping)  frequent nighttime awakenings  nightmares  teeth grinding  
 other: \_\_\_\_\_

## VISION

Do you have any concerns regarding your child's vision?  yes  no

If yes, please explain? \_\_\_\_\_

## HEARING

Do you have any concerns regarding your child's hearing?  yes  no

If yes, please explain? \_\_\_\_\_

## DEVELOPMENT

Walks all the way across a large room without falling or wobbling from side to side	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Takes shoes off by him/herself	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Feeds self	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Looks to caregiver(s) in stressful situations	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Shows affection	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Is having temper tantrums	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Says at least 4-10 words	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Pretends to talk	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Points to pictures that you name in a book	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving
Follows simple directions	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> evolving

## SAFETY

What type of car seat does your child use?

a 5 point (forward facing) toddler (convertible) seat in the back seat of the vehicle  
 a 5 point (rear facing) toddler (convertible) seat in the back seat of the vehicle  
 5 point (rear facing) infant carrier in the back seat of the vehicle  other: \_\_\_\_\_

Do you have a pool?  yes  no

If yes, what type?

above ground without a fence  in ground without a fence  above ground with a fence around the pool  
 above ground with a fence around the yard  in ground with a fence around the pool  in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



PATIENT NAME: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ZIP CODE: \_\_\_\_\_

## Lead Screening

A documented result of a blood lead test or a properly filled out Childhood Lead Risk Assessment Questionnaire must be attached to a Certificate of Child Health Examination form for purposes of admission to an Illinois Department of Children and Family Services or state regulated child-care facility, including those operated by a school district.

**Respond to the following questions by checking the appropriate answer.**

- |  |   |
|--|---|
| Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child live in or regularly visit a home that was built before 1978?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Is this child a refugee or an adoptee from any foreign country?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

M.A.R. 5.2010      Signature of Provider \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Tuberculosis Screening

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

**Respond to the following questions by checking the appropriate answer.**

- |   |   |
|---|---|
| Has a member of your family or a person who has contact with your child and tuberculosis disease?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has a family member had a positive tuberculin skin (TB) test?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries) like Mexico, South and Central America, Asia, India, and Eastern European countries? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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