NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: MALE☐ FEMALE☐	PHONE:
DATE OF SERVICE:	INFORMANT:

CHILD HEALTH RECORD

15 MONTH CHECKUP

HISTORY

☐ See new patient history form

INTERVAL HISTORY:
☐ NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y☐ N☐
Findings:

☐ **DEVELOPMENTAL SURVEILLANCE:**
- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
☐ Breast ☐ Bottle ☐ Cup
Milk (%): _____ Ounces per day: _____
Solid foods: _____
Juice: _____
Water source: _____ fluoride: Y☐ N☐

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ Hep A ☐ Hep B ☐ Hib ☐ IPV
☐ MMR ☐ PCV ☐ Meningococcal* ☐ Varicella
☐ MMRV ☐ Hib-Hep B ☐ DTaP-Hib
☐ DTaP-IPV-Hep B ☐ DTaP-IPV/Hib ☐ Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
Head Circumference: _____ (_____%)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Mouth/throat	☐ Genitalia
☐ Head/fontanels	☐ Teeth	☐ Extremities
☐ Skin	☐ Neck	☐ Back
☐ Eyes	☐ Heart/pulses	☐ Musculoskeletal
☐ Ears	☐ Lungs	☐ Hips
☐ Nose	☐ Abdomen	☐ Neurological

Abnormal findings:

Subjective Vision Screening: P☐ F☐
Subjective Hearing Screening: P☐ F☐

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:
- Development/Communication
- Nutrition
- Behaviors/Discipline
- Safety
- Routines

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

15 MONTH CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

15 Month Checkup

- Lead risk assessment*
- Encourage supervised outdoor play
- Establish consistent limits/rules and consistent consequences
- Separation anxiety common at this age
- Discipline constructively using time-out for 1 minute/year of age
- Limit TV time to 1-2 hours/day
- Make 1:1 time for each child in family
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Read books and talk about pictures/story using simple words
- Use distraction or choice of 2 appropriate options to avoid/resolve conflicts
- No bottle in bed
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Supervise within arm's length when near water/do not leave alone in bath water
- Use of front-facing car seat in back seat of car if >20 pounds
- Establish consistent bedtime routine
- Establish routine and assist with tooth brushing with soft brush twice a day
- Maintain consistent family routine

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

Ages 12 to 18 months

Yes	No	
☐	☐	Points to body parts (hair, eyes, nose, mouth) when asked to
☐	☐	Brings objects to you when asked
☐	☐	Hears and identifies sounds coming from another room or from outside
☐	☐	Gives one-word answers to questions
☐	☐	Imitates many new words
☐	☐	Uses words of more than one syllable with meaning ("bottle")
☐	☐	Speaks 10 to 20 words

*LEAD RISK FACTORS

Perform a blood lead test if parent/caretaker answers "Yes/Don't Know" to any of the questions below.	**Yes**	**Don't know**	**No**
• Child lives in or visits a home, day care, or other building built before 1978 or undergoing repair	☐	☐	☐
• Pica (Eats non-food items)	☐	☐	☐
• Family member with an elevated blood lead level	☐	☐	☐
• Child is a newly arrived refugee or foreign adoptee	☐	☐	☐
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (See Pb-110 for a list)	☐	☐	☐
• Food sources (including candy) or remedies (See Pb-110 for a list)	☐	☐	☐
• Imported or glazed pottery	☐	☐	☐
• Cosmetics that may contain lead (See Pb-110 for a list)	☐	☐	☐

The use of the Form Pb-110, Lead Risk Questionnaire is optional. It is available at www.dshs.state.tx.us/thsteps/forms.shtm. If completed, return the form to the Texas Childhood Lead Poisoning Prevention Program as directed on the form.

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:
http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf