FLORIDA DEPARTMENT OF HEALTH

18 Months up to 3 Year-Old Child Health History & Physical Check-up

PLEASE PRINT

PERSONAL: ☐ **Well child visit** ☐ **Parent/Caregiver Request**

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP

CHILD INTERVAL HISTORY:

MEDICAL HISTORY (any changes or concerns since last visit) ☐ NO ☐ YES (DESCRIBE)

FAMILY MEDICAL HISTORY **(any changes or concerns since last visit)** ☐ NO ☐ YES (DESCRIBE)

ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS: ☐ NO ☐ YES (DESCRIBE)

DENTAL HISTORY/ ISSUES: ☐ NO ☐ YES (DESCRIBE)

DEVELOPMENTAL ISSUES: ☐ NO ☐ YES (DESCRIBE)

BEHAVIORAL ISSUES: ☐ NO ☐ YES (DESCRIBE)

CURRENT MEDS: ☐ VITAMINS ☐ IRON

DEVELOPMENTAL ASSESSMENT:

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (Does this client use spoon, kicks/throws ball, walks alone, move to music, drop & pick-up toys, responds to "no", by 18 mos.;. Jump in place, knows name, age and sex, copies a circle by 2 yr)

☐ YES ☐ NO ☐ REFERRED Formalized Screening tool_____ Results_____

NUTRITIONAL ASSESSMENT

☐ BREAST MILK ☐ WHOLE MILK ☐ TABLE FOODS ☐ FLUORIDE ☐ CUP ☐ BOTTLE ☐ FORMULA:_____

Is this a WIC participant? ☐Yes ☐No ☐Referred

Is your home on:	Is city water fluoridated?	Age when weaned from breastfeeding:	Age when weaned from bottle:
☐ well water ☐ city water	☐ YES ☐ NO ☐ DON'T KNOW		

What other beverages does this child drink? (check all that apply):

☐ Soy milk ☐ Whole milk ☐ 2% reduced fat milk ☐ 1% low fat milk ☐ fat free milk ☐ tea ☐ Water with sugar

☐Water ☐Bottled Water ☐ 100% fruit juice ☐ Gatorade ☐ Fruit drinks ☐ soda

Nutrition supplements _____ ☐ other _____

How often does the child eat these foods?

Meat, poultry, fish, beans, or eggs
☐ daily ☐ some days ☐ never

Milk, yogurt, or cheese
☐ daily ☐ some days ☐ never

Vegetables
☐ daily ☐ some days ☐ never

Fruits
☐ daily ☐ some days ☐ never

Grains – breads, cereal, rice, or pasta
☐ daily ☐ some days ☐ never

Cookies, cakes, pies, candy
☐ daily ☐ some days ☐ never

Fried foods, French fries, sausage, hot dogs, bacon
☐ daily ☐ some days ☐ never

Physical Activity:

Does your child engage in at least one hour per day of physical activity?

Running? ☐Yes ☐No, Jumping? ☐Yes ☐No, Dancing? ☐Yes ☐No Playing outside? ☐Yes ☐No

How many hours does your child spend TV watching? #_____hours/ each day

How many hours does your child spend using the computer? #_____hours/ each day

How many hours does your child spend playing video games? #_____hours/ each day

LAB TESTS: ☐ **Previously Screened**

☐LEAD RISK ASSESSMENT (@ 1 mo.-6 yrs., if pos do blood test	☐ BLOOD LEAD TESTING (@ 12 & 24 mo; @ 36-72 mo, if not previously screened.)	☐ TB SCREEN/PPD RESULTS_____	☐ SICKLE CELL SCREENING	☐ Hgb/Hct ____ (15-18 mos)	☐ OTHER (Specify, as indicated)

Signature/Title_____ Date_____

Signature/Title_____ Date_____

DH 3105K, 09/08 (Replaces DH 3105A & DH 3105B)

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PHYSICAL EXAM

TEMP: PULSE: RESP: Type:	HEIGHT: Percentile:	WEIGHT: Percentile:	BMI **percentile for age**: (2 and up)

Check as appropriate √	**N**	**A**	**N=Normal A=Abnormal**	**COMMENTS**
1. Appearance				
2. Skin				
3. Head				
4. Eyes				
5. Ears				
6. Nose				
7. Mouth/Throat				
8. Teeth/Gums				
9. Nodes				
10. Heart				
11. Lungs				
12. Abdomen/Umbilicus				
13. Femoral Pulse				
14. External Genitalia				
15. Hip Exam				
16. Extremities				
17. Spine				
18. Neurological				
19. Other				

SENSORY SCREEN: VISION: (red reflex, Follows, cover-uncover)
☐ NORMAL ☐ ABNORMAL ☐ REFERRED

HEARING: (18 mo. Reacts to music, points to named objects, 2-3 word other than mama-dada, points to named body part; 2 yr. Uses some understandable speech, Combines 2 words, names, objects)
☐ NORMAL ☐ ABNORMAL ☐ REFERRED

DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? ☐ YES ☐ NO
(If NO, Describe)

IMMUNIZATIONS PLAN: DUE TODAY_____ ☐ ADMINISTERED ☐ DEFERRED/PARENT DECLINED ☐ NONE DUE

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

☐ CAR/ BOOSTER SEAT ☐ SAFETY- HOME/ POOL/ FALLS ☐ SLEEPING/ CRIB ☐ DAYCARE ☐ TANTRUMS ☐ POISONS
☐ TOILET TRAINING ☐ SKIN CARE /SUN PROTECTION ☐ DECREASED APPETITE ☐ TALK & NAME OBJECTS ☐ TEETHING
☐ FEVER EDUCATION ☐ DENTAL HYGIENE ☐ NO BOTTLE ☐ CUP, FINGER FOODS ☐ READ TO CHILD
☐ SOLID FOODS ☐ NUTRITION / SNACKS ☐ SELF FEEDING ☐ CHOKING, ASPIRATION ☐ 2ND HAND SMOKE
☐ PETS IN HOME ☐ SIBLING INTERACTION ☐ CONTROL TV VIEWING ☐ FIREARMS IN HOME ☐ LEAD EXPOSURE
☐ DOMESTIC VIOLENCE ☐ SHAKEN BABY SYNDROME ☐ POST PARTUM DEPRESSION ☐ DISCIPLINE/LIMITS & PRAISE
☐ OTHER _____ ☐ LITERATURE GIVEN _____

ASSESSMENT/DIAGNOSIS:	**PLAN/ORDERS/REFERRAL:**

RETURN APPT:	ORDERS REVIEWED BY:

Signature/Title_____ Date_____

Signature/Title_____ Date_____

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