



WELL CHILD VISIT

15 Month

Name _____ Age in Months _____ Date of Visit _____

Concerns/Discussion

- Speech
- Sleep
- Family adjustment
- Illness/Accidents
- Discipline
- Other Concerns
- Observe parent/Child interaction

Nutrition

Meals

- Frequency _____ times/day
- Food Variety _____

Bottle/Breast

- Frequency _____ times/day

Guidance

- 3 meals and 2-3 snacks per day
- Whole pasteurized milk until 2 years
- Discuss weaning from bottle/breast
- Offer variety of foods
- Do not "force" or punish
- Avoid food as a reward
- Choking hazards

Developmental/Behavioral

- 3-10 words
- Point to 1 or 2 body parts
- Understands simple commands
- Walking
- Feeds self with fingers

- Drinks from cup
- Stranger anxiety
- Temper tantrums
- Temperament/Parent description

Physical Exam

- General
- Wt _____ % _____
- Ht _____ % _____
- HC _____ % _____
- Monitor growth chart
- Temp _____
- Skin (Nevi, café au lait spots)
- Nodes
- Head
- Eyes
- Ears
- Nose
- Oropharynx
- Neck
- Chest/Breast
- Lungs
- Cardiovascular
- Abdomen
- Genitalia
- Hips/Extremities
- Neuro
- Evidence of Neglect/Abuse

Screening/Immunizations

Screening

- Hearing (exam & history)
- Vision (exam & history)
- Lead—Screen high risk (educate all parents)
- Anemia—Screen high risk
- Tuberculosis—PPD if high risk
- Dental
 - Discuss fluoride
 - Exam and refer if abnormal
 - Educate on care

Immunizations

- Per ACIP schedule (Record below)
- Review record & "catch up" as needed

Anticipatory Guidance

- Injury/Accident prevention (car, falls, burns, sunscreen, drowning, pets)
- Sleep—Discuss regular bedtime routine
- Discuss daycare
- Appropriate toys
- Ignore temper tantrums
- Discipline (time out)
- Discourage toilet training
- Care of minor injuries

Immunizations given:

Record all abnormal findings below.

Assessment and Plan: _____

PHN Referral (if indicated) _____ WIC Referral (if indicated) _____

Physician Signature: _____