18 MONTH OLD

www.pedsnw.net

NAME ______________________________

DATE ______________________________

MEDICAL HISTORY

Has your child had any reactions to medications or immunizations?
Does your child take any medications (daily or as needed)?
Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
Are there any major illnesses in the family? Which ones? __________
Are there any major changes or stresses in the family (moves, deaths, separation, etc)?
Is your child in day care?
Has your child ever been diagnosed with an immunodeficiency?
Has your child had any illnesses, hospitalizations, or surgeries that we are not already aware of?

NUTRITION

Is your child breastfed?
Does your child take a bottle?
Does you child drink anything other than milk and water?
Does your child eat food from all 4 food groups?

PREVENTIVE HEALTH

Has your child seen a dentist in the past 6 months?
Does your child always ride in a car seat and in the backseat?
Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Have those alarms been checked in the past 12 months?
Does your child live with anyone who smokes?

__________ How many hours of "screen time" (TV, movies, video games etc) is your child around per day?

REVIEW OF SYSTEMS *(Does your child have any current problems with the following?)*

eyes (crossing, not focusing, drainage, inflammation, etc)
hearing
coughing, breathing, shortness of breath, wheezing, turning blue, or limitation in activity level
vomiting, swallowing or eating
stooling (diarrhea, constipation, or blood in the stools)
urination (change in frequency, or blood in the urine)
extremities (feet, legs, arms, hands)
Has your child received blood, plasma, respigam, or gammaglobulin?

CONCERNS

Do you have any special concerns today?

Thanks for filling out this form.