EARLY HEAD START WELL BABY CHECKUP
15 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ Lead Risk Assessment
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____
- ❑ Blood Lead Test (Result Value: _____)
- ❑ Anemia Risk Assessment

  1. Do you ever struggle to put food on the table?
  ☐ *No* ☐ ***Yes - If Yes, Hgb/Hct test is required***

  2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
  ☐ *Yes* ☐ ***No - If No, Hgb/Hct test is required***
- ❑ Anemia Risk factors present
  - ☐ Hgb/Hct Test Results: _____

    *Date: __ /__ /__ *(If different from exam date)

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 3 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ *MMR 1 _____/_____/_____
- ❑ *HIB booster _____/_____/_____
- ❑ Varicella _____/_____/_____

*(on or after 1st birthday regardless of any Hib doses given prior to 1st birthday)

DEVELOPMENTAL MILESTONES

- ❑ Walks steadily
- ❑ Stoops to pick up objects and then keeps walking
- ❑ Crawls up stairs
- ❑ Tries to climb on objects
- ❑ Holds a cup well, starts to use a spoon
- ❑ Scribbles
- ❑ Says 3-6 words other than "mama" and "dada"
- ❑ Follows simple commands
- ❑ Points to things and body parts
- ❑ Recognizes own image in a mirror
- ❑ Likes looking at books
- ❑ Starts to say, "no," and may have tantrums

NUTRITION ASSESSMENT

☐ Breast ☐ Bottle ☐ Cup

☐ Milk: Type: _____ Ounces/day:_____

Juice: ☐ No ☐ Yes: _____

Regular bowel movements: ☐ Yes ☐ No _____

Feeding issues: ☐ No ☐ Yes: _____

Solid foods: ☐ No ☐ Yes: _____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins
- ❑ Drowning / water safety
- ❑ Dental care – nursing / bottle carries
- ❑ Storage of firearms
- ❑ Second hand smoke

COMMENTS/CONCERNS:

18 MONTH APPOINTMENT SCHEDULED:
_____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____