

18 Month to 3 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	WIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
Referred	

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? (eyes straight?, red reflex, fixation test, cover-uncover test) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (2 yr. Uses some understandable speech, combines 2 words, names objects; 3 yr. Uses 3-4 word sentences) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 18 mo. Uses spoon, kicks/throws ball, walks alone; by 3 years jumps in place; knows name, age, and sex; copies a circle) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DECREASED APPETITE <input type="checkbox"/> READ TO CHILD <input type="checkbox"/> TOILET TRAINING
<input type="checkbox"/> TEETH BRUSHING <input type="checkbox"/> CONTROL TV VIEWING <input type="checkbox"/> SAFETY-CARS & POOL <input type="checkbox"/> SUN PROTECTION <input type="checkbox"/> OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:

