

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_



**EIGHTEEN MONTH WELL CHILD CHECK**

**INTERVAL HISTORY**

Any changes in your family since last visit? <input type="checkbox"/> Move <input type="checkbox"/> Job change <input type="checkbox"/> Divorce <input type="checkbox"/> None <input type="checkbox"/> Other:
Any relatives diagnosed with new medical issues since last visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:

**SENSORY / BEHAVIORAL SURVEILLANCE**

Are you concerned about your child's hearing?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you concerned about your child's speech?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you concerned about your child's vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child hold things close when trying to see them?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have your child's eyes ever been injured?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Any concerns about your baby's growth / learning / behavior?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:

**ANEMIA / LEAD / ORAL RISK ASSESSMENT**

Do you ever struggle to put food on the table?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child have a sibling or playmate who has had lead poisoning?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child live/visit a house or daycare built before 1978?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child live near or are around adults who work in battery factory, steel mill or other industry?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child chew or eat paint chips or dirt?.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has your child spent >1 wk in South or Central America, Africa, or Asia since last blood test?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child use any ethnic folk remedies, imported cosmetics, or candies made outside the US?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child see a dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does your child's primary watery source have fluoride (i.e. city water)	<input type="checkbox"/> No <input type="checkbox"/> Yes

**ANTICIPATORY GUIDANCE:**

- Ask simple questions, confirm him/her answers, and use simple words to tell your child what to do.
- Put time aside for family time. Keep outings with a toddler brief (i.e. 1 hour or less).
- Don't expect a toddler to share. Give older kids a safe place for toys they don't want to share.
- Teach your child not to hit, bite, or hurt others.
- It is normal at this age for your child to alternate between being clingy and being independent.
- Spend time with each child. Make sure you are also taking care of yourself.
- Give your toddler many chances (10-15 tries) to try a new food. Allow mouthing and touching to learn about them.
- Call Poison Help (1-800-222-1222) if your child ate something poisonous.
- Hold your child's hand when walking by the road or driveway.
- Read books about potty training with your child. He/she is ready for potty training when: he can be dry >2 hours, knows when he is wet/dry, can pull pants down/up, wants to learn, can tell you if he is going to poo/pee. Praise your child whenever he/she sits on the toilet. Take your child to choose his/her favorite underwear.
- Play with your child every day by doing things he/she likes.
- Discipline your child with time-out, but keep it brief. Tell your child in simple words what she did wrong.