

Patient ID _____

Patients Name _____

PCP _____

DOB _____

Today's Date _____

18 Month Old Parent Observations

Are there any concerns you would like to discuss today? _____

Feedings/Sleep:

Any concerns about feedings or weight gain? Yes No

Does your child eat well (i.e. has consistent appetite, not too picky)? Yes No

Your child's diet consists of: (check all that apply)

- Breastfeeding Whole Milk (# of oz/day) _____ Juice (# of oz/day) _____
- Fruits Vegetables Meats Grains Table Foods

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) Yes No

Any concerns about sleep? Yes No

Development:

Are you reading to your child? Yes No

Does your child watch TV/tablet/phone/have other screen time? Yes No

If yes, how much screen time per day? _____

Do you have any concerns about your child's hearing or vision? Yes No

Any concerns about your child's development? Yes No

Does your child: (please check all that apply)

- use cup/spoon scribble follow 1-step commands
- run use 5-15 words help with dressing
- walk up stairs throw objects in play bring books to read
- stack 2-3 blocks point to 2 body parts show interest in other children

Social/Behavior:

If parent(s) work, who cares for your child? _____

Are there any family or social issues you would like to discuss? Yes No

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? Yes No

Is discipline (such as teaching, setting limits) a problem? Yes No

Safety/Preventative Health:

Are you brushing your child's teeth with a smear of fluoride toothpaste? Yes No

Has your child seen a dentist? Yes No

Is your home "child proofed"? Yes No

Is your home/car a smoke-free environment? Yes No

Does your child use a rear-facing car seat 100% of the time? Yes No

Utah Law: A child should be rear-facing until age 2 years & 30 lbs

Do you have any questions/concerns about immunizations? Yes No

Any illness or fevers in the last 24 hours? Yes No

Does your child have any allergies (that you know of)? Yes No

Please list any medications or supplements your child took this week: _____