

18 MONTH WELL CHILD EXAM

NAME: Bortner, Cassida VISIT DATE: 8/10/00 DOB: 2/4/99
 I.D. #: 67216061A Physician: G. Glass Adrienne Platt Actual Age: 78 Months
 (Medicaid/Ins) 67216061A ID #: G. Glass Adrienne Platt

KEY: Mark NI if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY			(2) PHYSICAL EXAM			(3) IMMUNIZATIONS GIVEN			
1. General health	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	13. WT <u>23.3/2</u>	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	if not done			
2. Illnesses	<input checked="" type="checkbox"/> Y	<input checked="" type="checkbox"/> Ab	14. HT <u>29.7</u>	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	32. Hep B # 3	<input type="checkbox"/> Y	<input type="checkbox"/> N	
3. Sleeping/nap	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	15. HC <u>34.1/4</u>	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	33. Varicella	<input type="checkbox"/> Y	<input type="checkbox"/> N	
4. Feeding breastfeeding _____ x/day milk _____ /day (24oz /day)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	16. Skin	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	34. IPV # 3	<input type="checkbox"/> Y	<input type="checkbox"/> N	
5. Balanced diet	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	17. Head, fontanel	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	35. OPV # 3	<input type="checkbox"/> Y	<input type="checkbox"/> N	
6. Vitamins/supplements/Fe	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	18. Eyes	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	36. DTaP, DTP # 4	<input type="checkbox"/> Y	<input type="checkbox"/> N	
7. Fluoride <u>twice a day</u>	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	19. Hearing	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	37. Up to date?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
8. Stools	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	20. Ears [TM], Throat, Nose	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	(6) KEY ANTICIPATORY GUIDANCE			
9. Urine	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	21. Teeth decay	<input type="checkbox"/> NI	<input type="checkbox"/> Ab				<input checked="" type="checkbox"/> * = Key items
10. Family status	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	22. Neck	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> *53. Child oriented routines			
11. Smoke free environment	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	23. Lungs	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> *54. Never leave child alone in car/home			
12. Child care plans <u>NUSA</u>	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> Ab	24. Heart, pulses	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 55. Smoke detectors			
(5) DEVELOPMENTAL MILESTONES			25. Abdomen	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 56. Keep home/car smoke-free			
40. Confident walk	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	26. Genitalia	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 57. Toddler car seat in back			
41. Walk backwards	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	27. Musc/Skel	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 58. Ensure water/playground safety			
42. Throw ball	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	28. <u>Gait</u> <u>toeing in</u>	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 59. Supervise constantly near hazards			
43. Vocab 15-20 words	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	29. Neuro	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 60. Cautions about pets			
44. Imitates words	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	30. Extremities	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 61. Sun exposure/sunscreen			
45. 2-word phrases	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	31. General hygiene	<input type="checkbox"/> NI	<input type="checkbox"/> Ab	<input checked="" type="checkbox"/> 62. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards			
46. Stacks 3 or 4 blocks	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	(4) SCREENING			<input type="checkbox"/> Y	<input type="checkbox"/> N		
47. Uses spoon and cup	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	38. If no previous lead test done, Blood lead test if on Medicaid, WIC, etc., or at risk:	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N		
48. Shows affection	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	• lives in pre-1960 housing	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N		
49. Follows simple directions	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	• lives in pre-1978 housing with renovations within 6 months	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N		
50. Scribbles	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	• lead poisoned sibling/playmate	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N		
51. Points to some body parts	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	39. Do PPD (if exposure risk)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N		
52. Can remove clothing	<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	if done, result	<input type="checkbox"/> Neg	<input type="checkbox"/> Pos	<input type="checkbox"/> Y	<input type="checkbox"/> N		
ASSESSMENT/ABNORMALS (Use reference numbers) PLAN			EPSDT only: Child needs assistance for follow up for testing/treatment				<input type="checkbox"/> Y	<input type="checkbox"/> N	

DKA to meds. & meds currently all solids. whole milk 4-8oz cups a day 1 nap 2 1/2 hrs afternoon

WRT @ under tongue at home mom, a. ardine grandpa 2 broths

refusal to eat
 HINT: refusal to eat
 daily to

PHYSICIAN SIGNATURE: [Signature]

RTC in 6 months

DATE: 8/10/00