Mclaren Medical Group

PEDIATRIC PHYSICAL EXAMINATION

AGE 18 Months

Date: _____ Age: _____ Accompanied By: _____

INTERVAL HISTORY / REVIEW OF SYSTEMS

See Pediatric/Adolescent History Form/Problem List/Med. List

Concerns/Additional History: _____

_____

_____

_____

Nutrition: ☐ Bottle ☐ Solid Foods _____

☐ Formula _____ ☐ Whole Milk

Amt/feeding _____ Frequency _____

Elimination: ☐ WNL _____

_____

Sleep: ☐ WNL _____

_____

Behavior: ☐ WNL _____

_____

Hearing: _____

Vision: _____

DEVELOPMENT

KEY: ☑ = Has achieved ☐ = Has not achieved

- ☐ Walks Up Stairs
- ☐ Voices 20 or More Wants
- ☐ Points to 5 Body Parts
- ☐ Mimics Parents' Tasks
- ☐ Stacks 3-4 Blocks
- ☐ Feeds Self with Spoon
- ☐ Scribbles
- ☐ Kicks/Throws Ball
- ☐ Runs
- ☐ Vocabulary 4-10 Words
- ☐ 2 Word Combos

EDUCATION

Discussed and/or handout given:

- ☐ Nutrition
  - ☐ Diet for Age
  - ☐ Milk/Juice Intake
  - ☐ Weaning from Bottle
- ☐ Elimination
- ☐ Sleep
  - ☐ Pre-bed Rituals
- ☐ Dental Care
- ☐ Behavior/Development
  - ☐ Social
  - ☐ Communication Skills - Read Regularly
  - ☐ Physical
  - ☐ Toilet Training
  - ☐ Discipline Issues
- ☐ Injury Prevention
  - ☐ Activity Supervision
  - ☐ Auto/Car Seat
  - ☐ Falls/Poison Control
  - ☐ No Strings Around Neck
  - ☐ No Shaking
  - ☐ Burns
    - ☐ Water Heaters
    - ☐ Smoke Detectors
    - ☐ Carbon Monoxide Detectors
    - ☐ Childproof Environment
  - ☐ Drowning
  - ☐ Firearm Hazards
- ☐ Passive Smoke Exposure
- ☐ Child Care
- ☐ Other: _____

PHYSICAL EXAMINATION

Weight _____ Height _____ Head Circumference _____

See Growth Chart

T: _____ P: _____ R: _____

KEY: ☑ WNL

☐ Not addressed or exceptions/abnormalities must be documented

- ☐ Gen. Appearance _____
- ☐ Head/Fontanel _____
- ☐ Eyes _____
- ☐ Ears _____
- ☐ Nose _____
- ☐ Mouth/Throat _____
- ☐ Lungs _____
- ☐ Heart _____
- ☐ Femoral Pulses _____
- ☐ Abdomen _____
- ☐ Genitalia _____
  - ☐ Male/Testes Down _____
  - ☐ Female _____
- ☐ Extremities _____
- ☐ Back _____
- ☐ Skin _____
- ☐ Neurologic _____

Comments: _____

_____

_____

ASSESSMENT

☐ Well child

_____

_____

_____

_____

_____

_____

PLANS/FOLLOW-UP

_____

_____

_____

_____

_____

☐ Next well child at age 2 years

IMMUNIZATIONS

☐ DTaP #4 ☐ HepB #3 ☐ Influenza Vaccine

☐ IPV #3 ☐ MCIR Updated

☐ Physician provided face-to-face counseling with the parent/guardian at the time of administration of (list number) _____ vaccine(s) at this visit.

SCREENINGS

☐ Lead Screening Date: _____

☐ Lead Level Date: _____

☐ Parent/guardian verbalized understanding of education/instructions

☐ See Progress Notes for additional documentation

Clinical Staff Signature: _____

Provider Signature: _____

Patient Name:

Date of Birth: