

# Jessica Davis MD

The New Mom's Family Doctor  
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## FIFTEEN to EIGHTEEN MONTH WELL CHILD VISIT

GENERAL ISSUES			DISCUSSION TOPICS
Yes	No	Overall, I feel confident that my child is doing well	
Yes	No	I have enough help with my child	
No	Yes	There have been recent changes or stresses in our family	
No	Yes	My child attends daycare. _____ Days a week?	
No	Yes	Parenting is harder than I thought it would be Who lives with you and your child? _____	
FEEDING			*****
No	Yes	I have questions about my child's diet/nutrition My baby takes breast milk _____ times per day, or whole milk _____ oz per day My child eats _____ meals per day and _____ snacks per day	Continue breastfeeding Vitamin D/iron sources Decreased appetite Limit juice, avoid sweets Encourage table foods, self-feeding, mealtime routines Cleaning teeth/1st Dentist
No	Yes	My baby drinks juice _____ oz per day	
No	Yes	My baby has a bottle at bedtime	
No	Yes	I have questions about teething / tooth care _____	
SLEEPING / VOIDING / STOOLING			*****
Yes	No	I am satisfied with my child's sleep schedule. # naps per day _____ #hrs sleep at night _____ I get my child to sleep by: <b>Feeding / Rocking / Pacifier / Self / Other</b>	Need for bedtime routine Fiber in diet Normal variation No bottle at bedtime Delay toilet training
No	Yes	My child wakes up in the middle of the night. To get him/her back to sleep I _____	
Yes	No	My baby pees and poops normally. # Wet diapers per day _____ # Stool diapers _____	
No	Yes	I have questions about toilet training _____	
BEHAVIOR / DEVELOPMENT			*****
No	Yes	I have questions about my child's development	R-PDQ if concerns Increased vocabulary Social games/books Imitative behavior Scribbling Climbing/exploring Temper tantrums Discipline/time out
Yes	No	My child points to things to show them to me	
Yes	No	My child can say mama/dada and at least 3 other words (approx # _____ )	
Yes	No	My child walks well	
Yes	No	My child bends over to pick things up	
Yes	No	My child can scribble	
Yes	No	My child likes to play pretend games	
No	Yes	I have questions about discipline _____	
PREVENTION			*****
No	Yes	My baby lives with someone who smokes cigarettes	Risk of tobacco exposure Assess TB risk
No	Yes	My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa	
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No	Yes	I have a family member who has had Tuberculosis	Correct use of car seats Pan handles turned in Poison control 800-222-1222 Choking hazards Burn prevention Water safety No plastic bags/balloons
Yes	No	My child always rides in a car seat in the back seat	
Yes	No	My baby is never left alone in the car or house	
Yes	No	Our electrical outlets are covered	
Yes	No	Poisons/cleaners/tools/matches are kept locked and/or out of reach	
Yes	No	I have smoke alarms and test them regularly	
Yes	No	We have gates in front of stairs, windows and doors are always locked	
Yes	No	My hot water heater is set to 120°F	
Yes	No	I feel that my child is safe in our home and/or at daycare	
No	Yes	Is there anything else you want to discuss today?	
<b>Mortality leaders: Accidental injuries and falls, drowning, auto accidents, burns, choking</b>			