

Your child is 18 months old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
<input type="checkbox"/> Well Visit <input type="checkbox"/> Allergies <input type="checkbox"/> Cold/flu <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Development <input type="checkbox"/> Earache <input type="checkbox"/> Fever <input type="checkbox"/> Growth/nutrition <input type="checkbox"/> Injury <input type="checkbox"/> Rash <input type="checkbox"/> Red eyes <input type="checkbox"/> Sore throat <input type="checkbox"/> Speech <input type="checkbox"/> Temper <input type="checkbox"/> Vaccines <input type="checkbox"/> Vomiting <input type="checkbox"/> Other (please explain): _____ Briefly describe your concern: _____	
Health Changes	
Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats 3 meals and at least 1 snack each day:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child eats a variety of fruits and/or vegetables over the course of a week:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child eats iron-rich foods, like finely cut/ground meat, beans, iron-fortified cereal:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child feeds themselves:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child still drinks from bottles:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child drinks more than 20 ounces of formula or whole milk per day:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you worried that your child is often constipated or having diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____	
Dental Health	
Do you clean your child's teeth every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child seen a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your water source have fluoride?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
My child:	
Knows at least 2 body parts:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Says more than 10 words:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Engages others to play and points to objects to show me:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follows simple directions:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Walks up stairs using 2 feet per step:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Climbs onto furniture and sits on a small chair:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tries to use utensils for feeding themselves, or tries to scribble:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Throws a ball:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you read to your child daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	
My child sleeps through the night:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child has a nap schedule and sleep routine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child is usually easy to put to sleep:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Safety	
My child rides in a rear-facing car seat in the back seat of the car for every car ride:	<input type="checkbox"/> Yes <input type="checkbox"/> No
We have gates across stairs and safety guards on windows:	<input type="checkbox"/> Yes <input type="checkbox"/> No
We have cleaning supplies, medicines, and matches locked away:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	<input type="checkbox"/> Yes <input type="checkbox"/> No
The buildings where my child lives or regularly visits were built after 1978 or, if built before 1978, have not been renovated in the past 6 months and do not have peeling paint:	<input type="checkbox"/> Yes <input type="checkbox"/> No
We avoid giving my child choking hazards, like hard, round, or sticky food, balloons, small toys or other objects:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Our furniture is bolted to the wall to prevent tipping:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your plan for childcare? <input type="checkbox"/> Home with parent <input type="checkbox"/> Family member <input type="checkbox"/> Nanny or Sitter <input type="checkbox"/> Childcare center	
Do you need assistance finding affordable and safe childcare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child watch TV or movies, or play games on a phone or tablet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there anyone who lives in your home or cares for your child who:	
– Smokes or vapes tobacco or marijuana:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Uses prescription pain medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Uses other drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 12 months, have you:	
– Run out of food or been worried your food would run out before there was money to buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Worried about housing or had to move?	<input type="checkbox"/> Yes <input type="checkbox"/> No
– Had difficulty getting other supplies and services you need to care for your child? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOT TO BE FILED IN THE MEDICAL RECORD