18 Months

Does the child have any medical problems? ☐ yes ☐ no If yes, please list_____

_____

_____

_____

_____

Has the child had any surgeries? ☐ yes ☐ no If yes, please list type

_____

_____

_____

_____

_____

Is there a family history of illness or disease? Immediate family only. ☐ yes ☐ no If yes, please list

_____

_____

_____

_____

_____

Who lives in the home with the child?

_____

_____

_____

_____

_____

Does anyone in the home smoke? ☐ yes ☐ no

Is the child taking any medications on a daily basis? ☐ yes ☐ no If yes, please list all medications_____

_____

_____

_____

Is the child allergic to any medication? ☐ yes ☐ no If so, what?

_____

_____

Please list birth history:

Hospital_____

_____

_____

Delivery type: ☐ vaginal ☐ C-section

Full- term? ☐ yes ☐ no How many weeks were you when child was born?_____

Birth weight?_____

Inches? _____

Did child pass hearing screen? ☐ yes ☐ no

Did child receive Hep B vaccine? ☐ yes ☐ no

Any problems at delivery? ☐ yes ☐ no If yes, please list_____

_____

_____

_____

_____

Excessive sun exposure? ☐ yes ☐ no

Does child use a car seat? ☐ yes ☐ no

Is the home child proofed? ☐ yes ☐ no

Fire extinguishers? ☐ yes ☐ no

Smoke detectors? ☐ yes ☐ no

Any guns in the home? ☐ yes ☐ no

Any pets in the home? ☐ yes ☐ no If yes, what kind?

_____

Any concerns with hearing? ☐ yes ☐ no

Any concerns with vision? ☐ yes ☐ no

Any problems since last visit? ☐ yes ☐ no

ER visits? ☐ yes ☐ no

18 Month Questionnaire

Please check all the boxes that apply

Feeding:

☐ Breast feeding
☐ Formula feeding
☐ Early introduction of solid baby food
☐ Spitting up after feeding
☐ Supplemental feeding after breast
☐ Pumping and bottle
Feeding

Formula:
☐ whole milk
☐ 2% milk
☐ 1% milk
☐ Similac
☐ Enfamil
☐ Nestle Brand
☐ Gerber Good Start
☐ Other:_____

Bottle Feeding Volume:
☐ Less than 20 oz. a day
☐ More than 20 oz. a day

Feeding Frequency:
☐ Every 2 hours
☐ Every 3 hours
☐ Every 4 hours
☐ Every 5 or more hours

Using Cup:
☐ uses cup
☐ uses bottle only
☐ uses both bottle and cup
☐ phasing out of bottle

Juice:
☐ no juice
☐ drinks juice
☐ 4 oz/day
☐ 6 oz/day
☐ 8 oz/day
☐ 10 oz/day

Solids:
☐ all 4 food groups
☐ picky eater
☐ good appetite
☐cereal
☐ vegetables
☐ fruits
☐ meats
☐ no reactions
☐ reactions

Elimination Stool:
☐ regular
☐ irregular
☐ soft BM
☐ Hard BM
☐ Constipation
☐ Diarrhea

Elimination Urine:
☐ Urinating normal
☐ Trouble urinating

Sleep/Position:
☐ through night
☐ wakes to feed
☐ wakes once
☐ wakes twice
☐ wakes >3 times
☐Parent's room
☐ Infant's room

Temperament:

- ☐ Happy
- ☐ Fussy
- ☐ Easy
- ☐ Demanding
- ☐ Fussy but consolable

Gross Motor Assessment:

- ☐ runs
- ☐ walks backwards
- ☐ kicks a ball
- ☐ throws a ball

Fine Motor Assessment:

- ☐ stacks 2 items on top of each other
- ☐ scribbles
- ☐ turns pages

Communication:

- ☐ uses 3-6 words
- ☐ able to combine 2 words

Social:

- ☐ able to use spoon or fork
- ☐ helps around the house
- ☐ able to remove clothes
- ☐ imitates housework

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (for example, you've seen it once or twice), please answer as if the child does not do it.

		Yes	No
1.	Does your child enjoy being swung, bounced on your knee, etc.?	❐	❐
2.	Does your child take an interest in other children?	❐	❐
3.	Does your child like climbing on things, such as up stairs?	❐	❐
4.	Does your child enjoy playing peek-a-boo / hide-and-seek?	❐	❐
5.	Does your child ever pretend, for example, to talk on the phone or take care of doll or pretend other things?	❐	❐
6.	Does your child ever use his/her index finger to point, to ask for something?	❐	❐
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	❐	❐
8.	Can your child play properly with small toys (i.e. cars or bricks) without just mouthing, fiddling, or dropping them?	❐	❐
9.	Does your child ever bring objects over to you (parent) to show you something?	❐	❐
10.	Does your child look you in the eye for more than a second or two?	❐	❐
11.	Does your child ever seem oversensitive to noise? (i.e. plugging his/her ears?)	❐	❐
12.	Does your child smile in response to your face or your smile?	❐	❐
13.	Does your child imitate you? (i.e., if you make a face will you child imitate it)?	❐	❐
14.	Does your child respond to his/her name when you call?	❐	❐
15.	If you point at a toy across the room, does your child look at it?	❐	❐
16.	Does your child walk?	❐	❐
17.	Does your child look at things you are looking at?	❐	❐
18.	Does your child make unusual finger movements near his/her face?	❐	❐
19.	Does your child try to attract your attention to his/her own activity?	❐	❐
20.	Have you ever wondered if your child is deaf?	❐	❐
21.	Does your child understand what people say?	❐	❐
22.	Does your child sometimes stare at nothing or wander with no purpose?	❐	❐
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	❐	❐

Have you ever filled out this form before? **Yes** **No**

How easy was it to fill out this form (Please circle one):

Very Easy Easy Somewhat Easy Not Easy at All

PEDIATRIC ASSOCIATES OF WESTERN CT, PC

NAME: _____ **DOB:** _____