

Eighteen Month Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out **BOTH SIDES**

- | | | | |
|---|---------|--------|--------|
| Does your child run? | Yes | No | Unsure |
| Does your child walk up stairs? | Yes | No | Unsure |
| Can your child kick a ball? | Yes | No | Unsure |
| Can your child feed himself with a spoon? | Yes | No | Unsure |
| Can your child take some of her clothes off? | Yes | No | Unsure |
| Can your child scribble? | Yes | No | Unsure |
| Can your child point to at least one part of his body when asked? | Yes | No | Unsure |
| Can your child use at least 4 to 10 words? | Yes | No | Unsure |
| Is your child beginning pretend play? (feed a doll, push a toy car) | Yes | No | Unsure |
| Does your child point out planes, birds or other objects to you? | Yes | No | Unsure |
| Does your child like to play with other kids? | Yes | No | Unsure |
| Does your child follow simple commands? ("get the ball") | Yes | No | Unsure |
| How many ounces of milk does your child drink in 24 hours? _____oz; | whole | lowfat | nonfat |
| How many ounces of juice does your child drink in 24 hours? | _____oz | | |
| Is your child completely weaned from the bottle? | Yes | No | |
| Does your child eat meat (such as fish, chicken, beef, pork)? | Yes | No | Unsure |
| Does your child sleep through the night, without feeding? | Yes | No | Unsure |
| Do you read to your child daily? | Yes | No | Unsure |
| Is your child showing interest in the potty? | Yes | No | Unsure |
| Is your home child-proofed? | Yes | No | Unsure |
| Do you usually use sunscreen for your child when outdoors? | Yes | No | Unsure |
| Do you have other safety concerns in your home? | Yes | No | Unsure |

If so, please describe _____

PLEASE TURN OVER

Your Child's Name: _____

Who provides daytime care for your child? _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including fluoride? If so, please list below:

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No

Has a family member had a positive tuberculin skin test? Yes No

Was your child born in a high-risk country?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoHas your child traveled to (or had contact with people
who live in) a high-risk country for more than one week?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoDo you have any concerns about your child's development, or any
other concerns you would like to discuss with your provider? Yes No*If so, what are your concerns?*



Modified Checklist for Autism in Toddlers (M-CHAT)

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

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