

MUNDELEIN PEDIATRICS

18 Month Well Exam

Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

- 1. Sleeps through the night: Yes/No Concerns: _____
(____) hours per night
(____) hours from naps during the day
- 2. Good eating habits: Yes/No Concerns: _____
Milk: (____) ounces of milk daily
Fruit juice: (____) ounces of fruit juice daily
- 3. Urinating well: Yes/No Concerns: _____
- 4. Normal bowel movements: Yes/No Concerns: _____
- 5. Rides in a rear-facing car seat in the back seat: Yes/No Concerns: _____
- 6. Takes Vitamins: Yes/No Product Name: _____
- 7. Emergency room visits: Yes/No
- 8. Illness since last visit: _____

Please circle the answer that most appropriately describes your home environment:

- 1. Smoke-free home and car: Yes/No
- 2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
- 3. Firearms at home: Yes/No If yes; are safety precautions taken: Yes/No
- 4. Television/Video game time: Yes/No Hours per day: _____
- 5. Daycare: None/Relative/Center/Babysitter
- 6. Primary care taker: Mom/Dad/Grandparents
- 7. Household composition:
Adult(Names/Ages): _____
Children(Names/Ages): _____
- 8. New health problems in parents or siblings: _____
- 9. Past vaccine reactions: Yes/No
- 10. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

