MUNDELEIN PEDIATRICS

15 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: _____
9. Developmentally: drinks from a sippy cup, thumb-finger grasp, imitate sounds, indicate individual wants (not crying), understands no, follow directions (2 out of three times), three words other than mama/dada, walks well, walks up steps with help, draws line with crayon, builds a tower of 3 cubes

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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

_____

_____

_____

Patient Name: _____ **DOB:** _____

Childhood Lead Assessment Questionnaire	Yes	No	Unsure
1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high-risk ZIP codes LAKE: 60040,60041,60064,60085,60099, MCHENRY: 60034, 60180 and all CHICAGO Zip codes			
2. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?			
3. Does this child have a sibling with a confirmed blood level of 5mcg/dL or higher?			
4. In the past year, has this child been exposed to repairs, repainting, or renovation of a home built before 1978?			
5. Is this child a refugee or an adoptee from any foreign country?			
6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)?			
7. Does this child live with someone who has a job or a hobby that may involve lead (jewelry making, building renovation or repair, bridge construction, pluming, furniture refinishing, leaded glass, lead shots, bullets or lead fishing sinkers?)			
8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood level of 5mcg/dL or higher?			
9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5ppb or higher)?			
10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead?			

Tuberculosis Screen Questionnaire	Yes	No	Unsure
1. Has your child been exposed to anyone with the confirmed or suspected TB?			
2. Has your child been exposed to any family member or close friend who has been in jail in the last five years?			
3. Has your child recently emigrated from Asia, the Middle East, Africa or Latin America?			
4. Has your child recently traveled to Asia, the Middle East, Africa or Latin America?			
5. Does your child have HIV or live in a home with someone who has HIV?			
6. Has your child been exposed to anyone with HIV, homeless residents or nursing homes, teens or adults in jail, or migrant farm workers?			
7. Have you (parent) emigrated with known TB status from Asia, the Middle East, Africa or Latin America; Do you travel to these areas or have contact in your home with people from these areas with known TB status?			
8. Does your child live in an area that you know to have a high prevalence of TB?			
9. Does your child have diabetes, chronic renal failure, malnutrition, or a problem with the immune system that he/she was born with or acquired later in childhood?			