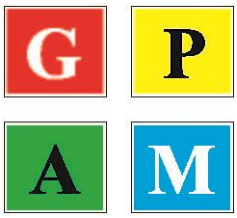
Patient Name_____DOB_____



15 Months Review of Systems

Drinks from a cup	Yes	No	Comment
Brush child's teeth 2 times per day	Yes	No	Comment
Does your child still use a bottle	No	Yes	Comment
Has child been to dentist	Yes	No	Comment
Puts blocks in a cup	Yes	No	Comment
Walks well	Yes	No	Comment
Bends down without falling	Yes	No	Comment
Says 2 to 3 words	Yes	No	Comment
Follows simple commands	Yes	No	Comment
Tries to do what you do	Yes	No	Comment
Brings toys over to show you	Yes	No	Comment
Listens to a story	Yes	No	Comment
Concerns about how child hears	No	Yes	Concerns
Concerns about how child sees	No	Yes	Concerns
Any concerns for crossing, drifting, or lazy eyes	No	Yes	Comment

Hip Dysplasia Risk:

Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment

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Anticipatory Guidance:

Parent worried about child's weight	No	Yes	Comment
Hours per day child watches TV	None	Less than 2	How many Hrs?____
Plays actively for an hour or more per day	Yes	No	Comment
Has a regular bed time routine	Yes	No	Comment

Patient Name_____

Let your child fall asleep on his/her own	Yes	No	Comment
Parent sets limits for child	Yes	No	Comment
Always uses car seat in back seat of car	Yes	No	Comment
Keeps household cleaners, chemicals and medications are locked up	Yes	No	Comment
Has number for poison control near the telephone	Yes	No	Comment
Does anyone smoke around child	No	Yes	Comment
Has a working smoke and carbon monoxide Detector on every floor of the home	Yes	No	Comment.
Water temp <120 degrees	Yes	No	Comment