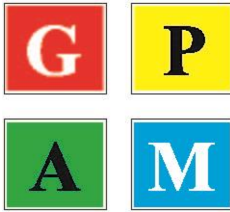
Patient Name_______________Date of Birth__________



Risk Assessment 18 Months

Any relatives developed new medical Problems since your last visit	No	Yes	Unknown	Comment ________________
Concerns about how child hears	No	Yes	Concerns	
Concerns about how child sees	No	Yes	Concerns	
Concerns about how child speaks	No	Yes	Concerns	
Any concerns for crossing, drifting, or lazy eyes	No	Yes	Comment	
Have any members of the family or your Child's playmates had high blood lead level	No	Yes	Unknown	Comment
Does child live/visit house built before 1978 currently being renovated	No	Yes	Unknown	Comment
Does child live/visit a house/apartment building built before 1950	No	Yes	Unknown	Comment
Born in country outside of the United States	No	Yes	Unknown	Comment
Traveled or had contact with high TB risk populations longer than a week	No	Yes	Unknown	Comment
Family member or contact had tuberculosis or positive TB skin test	No	Yes	Unknown	Comment
Is the child HIV Infected	No	Yes	Unknown	Comment
Diet includes iron-rich foods such as meat, eggs, iron fortified cereal, or beans	Yes	No	Comment	
Do you have a dentist for your child	Yes	No	Comment	
Primary water source contains fluoride	Yes	No	Comment	
Teaches child that behaviors like hitting are not ok	Yes	No	Comment	
Plays actively for an hour or more per day	Yes	No	Comment	
Parents set limits for child	Yes	No	Comment	
Hours per day child watches TV	None	Less than 2		# of Hours______

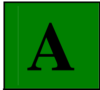
Patient Name____________________

Date of Birth____________________

Child points to what he/she wants, calls some things by name, and waves bye	Yes	No	Comment	
Has a working smoke and carbon monoxide Detector on every floor of the home	Yes	No	Comment	
Parent knows the number for poison control	Yes	No	Comment	
Keeps child away from stove	Yes	No	Comment	N/A
Has a gate on stairs	Yes	No	Comment	N/A
Keeps furniture away from windows and uses window guards on 2nd floor windows	Yes	No	Comment	N/A
Have a gun in home, or in any home child sleeps in	No	Yes	Comment	
If so are guns unloaded and locked away	Yes	No	N/A	

18 Months Development

Laughs in response to others	Yes	No	Comment
Runs	Yes	No	Comment
Walks up steps	Yes	No	Comment
Speaks 6 words	Yes	No	Comment
Uses spoon and cup without spilling most of the time	Yes	No	Comment
Points to 1 body part	Yes	No	Comment
Stacks 2 small blocks	Yes	No	Comment
Helps around the house	Yes	No	Comment



GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

Child's Name: ____

Date of Birth: ____

Today's Date: ____

Please fill out the following about how your child **usually** is. 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.

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