Patient intake for 15 MONTH HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:
Verbal Sign language Written Assistive Communication Device

Preferred method of learning:
Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:
No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.
If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

◆ Do you suspect your toddler is in pain? **Staff- Evaluate pain with FLACC Scale***	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____	(◆ **Staff- Request Records*)**	

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently deployed or on extended duty outside of the immediate area?	**YES**	**NO**
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	**YES**	**NO**

Nutrition

Feeding Method?

Breast Bottle Spoon/Fork Sippy Cup/Straw Other_____

Feeding Type?

Breastmilk Formula Whole Milk 2% Solids Other: _____

Oral Health

In what city & county does your child live?_____

Do you have any concerns about your child's oral health? YES NO

Has your child had a dental cleaning/check-up? YES NO

Do you brush your child's teeth using fluoride toothpaste? YES NO

Developmental Milestones

Walks unassisted?	YES	NO
Understands & follows simple commands (ie: "get the ball"?)	YES	NO
Drinks from a cup with little spilling?	YES	NO
Listens to a story?	YES	NO
Brings and shows toys?	YES	NO
Regularly uses 3 words?	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	**YES**	**NO**

Family history/Surgeries. Check all that apply.

Family History	**Patient** Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
♦To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

<u>You are DONE! Please keep your paperwork with you and wait to be called back.</u>

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY programs for recognition! *****

(Below for Office Staff)

Weight:_____kg

Length: _____cm

Head Circumference: _____cm

Heart Rate: _____ bpm

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

15 Month Health Supervision

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process

Click on me to go to the "**HealthyChildren.org**" Website! An American Academy of Pediatrics (AAP) guide to your child's milestones, growth and development. Search by age.

Your child's growth:

Weight:_____lb. Percentile:_____

Length: _____in. Percentile:_____

Head Circumference:_____cm. Percentile:_____

Feeding

- Limit milk to 24 oz per day and try to give mostly with meals.
- Continue to give 3 meals and 2-3 snacks per day.
- Avoid foods that may cause choking (peanuts, hot dogs, popcorn, raw carrots)

Your Changing Toddler

- Follow a regular bed-time routine and schedule. Minimize interaction with toddler at night during awakenings.
- Avoid the use of computers, TV, or videos
- Sing, speak and read to your toddler often.
- Show and tell your toddler what you want them to do.
- Use distraction to stop tantrums when you can.
- Limit the need to say "No" by making your home and yard safe for play.
- Let your child choose between 2 good things for food, drinks, or books.
- Brush teeth twice daily. Only give water after brushing teeth at night.
- Take your child for a first dental visit if you have not done so.

Safety

- Use a rear-facing car safety seat in all vehicles until age 2 years old.
- Never put your toddler in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Never leave your toddler alone near water.
- Place gates on stairs.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

Immunizations

- Infanrix (Diptheria, Tetanus, Pertussis) #4
- Pedvax #3 (Haemophilus Influenza Type B)
- Prevnar 20 #4 (Streptococcal pneumoniae)
- Annual Influenza (2 doses for first time influenza vaccination)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: https://centercitypediatrics.com/wait-worry-panic/

Next health supervision appointment: 18 months of age.

Patient specific guidance:

_____

_____