



18 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB: _____ Male Female

Physician Signature: _____

Instructions: Please answer the questions below about your child by choosing YES or NO.
These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
Feeding/ Nutrition		
Is your child still breast feeding?	NO	YES
Is your child taking formula or milk well?	YES	NO
How many ounces per day?		
Which formula or milk?		
Does your child have fruits or vegetables at every meal?	YES	NO
Are you giving your child mostly whole grains?	YES	NO
Do you avoid giving your child choking foods (raw vegetables, nuts, hotdogs, popcorn)?	YES	NO
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	NO	YES
Does your child still drink from a bottle?	NO	YES
Does your child drink juice or other sweetened drinks?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Do you have a dentist for your child?	YES	NO
Elimination		
Does your child have any problems with bowel movements (pooping)?	NO	YES
Do you have any questions about toilet training?	NO	YES
Activity/Exercise/Screen time		
Does your child watch TV?	NO	YES
Do you play and read to your child every day?	YES	NO
Sleep		
Does your child sleep through the night?	YES	NO
Do you have a bedtime routine?	YES	NO
Does your child fall asleep on their own in their own bed?	YES	NO
Social Stressors		
Are you able to take some time for yourself?	YES	NO
Have you had any major changes or stresses in your family recently?	NO	YES
Do you ever worry your family will go hungry?	NO	YES
Do you have daycare concerns?	NO	YES
Does your partner ever hurt you or your children?	NO	YES

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Behavior		
Does your child display excessive tantrums?	NO	YES
Do you have questions about discipline?	NO	YES
Do you praise your child when they are behaving well?	YES	NO
Development		
Does your child know two body parts?	YES	NO
Does your child have a vocabulary of six words?	YES	NO
Does your child understand and respond to simple requests?	YES	NO
Does your child indicate what they want by pointing or pulling, etc?	YES	NO
Does your child wave bye-bye?	YES	NO
Can your child stack two small blocks?	YES	NO
Can they use a spoon and cup without spilling most of the time?	YES	NO
Do they run well?	YES	NO
Can they climb up and down stairs by holding on?	YES	NO
Lead		
Are you living in a house built prior to 1978?	NO	YES
Is there any peeling or chipping paint?	NO	YES
Is there any recent, ongoing, or planning of remodeling?	NO	YES
Has a sibling or playmate ever had lead poisoning?	NO	YES
Safety		
Is your child's crib mattress at the lowest position?	YES	NO
Do you have a swimming pool, pond, or lake near your home?	NO	YES
Do you keep plastic bags and latex balloons away from your baby?	YES	NO
Does your child ride in a rear facing safety seat, in the back seat?	YES	NO
Is your infant exposed to anyone who smokes?	NO	YES
Are there working smoke detectors and carbon monoxide detectors in the home?	YES	NO
Do you have a gate on your stairs?	YES	NO
Do you have a fire escape plan?	YES	NO
Do you keep you child away from the stove?	YES	NO
Do you have the number for Poison Control?	YES	NO
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	YES	NO
Do you keep furniture away from windows or use window guards?	YES	NO
Tuberculosis		
Has a family member or contact had tuberculosis disease?	NO	YES
Has a family member or contact had a positive TB skin test (PPD)?	NO	YES
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
Has your baby traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about your baby's hearing?	NO	YES
Do you have any concerns about your baby's vision?	NO	YES