18 MONTH WCC - 18 MESES DE EDAD

Patient Name (Nombre): _____ Age of Patient (Edad): _____
Relationship to Patient (Relacion al paciente)_____Date of Birth(Fecha de nacimiento):_____

I. FAMILY (Please complete the following) FAMILIA (Por favor complete el siguiente)
Any changes in the household since last visit?(Ha habido cambios en el hogar desde la última visita)? Yes/Si No
Number of adults and children living in home(Numero de adultos en casa):____ Adults/Adultos ____ Children/Niños
Does anyone in the home smoke (Alguien en casa fuma)? Yes/Si No
Is your child in daycare (Esta asistiendo su bebe una guardria)? Yes/Si No, If yes, name:(Cual)?_____
Any pets (Hay mascotas en el hogar)? Yes/Si No Inside or Out (Adentro o Afuera)
Home water supply(Que Tipo de agua usa en el hogar): City/Cuidad Well/Poso Other/Otro:_____

II. FOOD (COMIDA)
Please Circle all that apply / Por favor, circule las que apliquen: Bottle / Botella Breast/Pecho Cup/Taza
Usual Number of Servings Per Day/Generalmente en numero porciones por día:
_____ Milk/Leche (Circle One/Círculo de su elección): Whole/Entera Soy/Soya 2% ____Formula
_____ Fruit/La Fruta
_____ Vegetables/Vegetales
_____ Meat, poultry, fish, eggs, & beans/Carne, aves de corral, pescado, huevos y frijoles
_____ Bread, cereal, rice, and pasta / Pan, cereal, arroz y pasta

III. DEVELOPMENT (DESAROLLO(Please mark all that apply to your child)(Marque todos los que hace su hijo(a))
___ Drinks from a cup/Bebidas de una copa ___ Says at-least 6 words/Dice al menos 6 palabras
___ Brings items when asked/Trae objetos cuando se le preguntó
___ Asks for familiar toys that are not around/Pide juguetes familiares que no estan alrededor
___ Uses voice to get what he/she wants or to communicate /Utiliza su voz para conseguir lo quiere o para comunicar

IV. CHILDS HEALTH (SALUD DEL PACIENTE)
__ Allergies(Alergias)__ Developmental delay(Retraso de desarollo) __Learning disorder(Desorden de aprendiziaje)
__ Asthma (Asma) __ Ear Infections(Infecciones de oido) __Bladder/Kidney (Vejiga/Riñon)
__ Operations/Hospitalizations (Operaciones/Hospitalizaciones)
__ Hearing/Vision problems(Problemas de audicion/visión)
__ Other(Otro): _____

V. CONCERNS / PREOCUPACIONES:
__ Rashes/Infections - Erupciones / Infecciones __ Hearing/Ear - Audición / Oído __ Fractures - Fracturas
__ Bowel Movement - Movimiento intestinal __ Urinayr frequency/pain - Frecuencia / dolor urinario
__ Seizures/Coordination/ Walking - Convulsiones / Coordinación / Caminar
__ Heart Murmur/trouble breathing, wheezing - Soplo cardíaco / dificultad para respirar, sibilancias
__ Other – Otro: _____

MEDICATIONS TAKEN DAILY(MEDICAMENTOS TOMADAS DIARIO):_____

What concerns do you have for today's visit (Anote cualquier preoucupación o pregunta para la doctora la doctora)?

_____

**RECENT CHANGES (Hay un cambio de): __ Address/Dirrecion__ Cell/Work Contact?Telefono __ Other/Otro

_____

Parent/Guardian Signature(Firma del Padre/Tuto):_____Date/Fecha: _____

***FILL OUT THE BACK SIDE / RELLENA LA PARTE POSTERIOR ***

TB Information / Información sobre tuberculosis

TB is a disease caused by TB germs and is usually transmitted by an adult person with active TB disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child. Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, wt loss of 10 or more pounds over a short period of time, fever, chills, and night sweats. A person can have TB germs in his or her body and not have active TB disease. TB is preventable and treatable. TB skin resting is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the US to prevent TB. The skin test is not a vaccination against TB. (La TB es una enfermedad causada por los gérmenes de la tuberculosis y generalmente es transmitida por una persona adulta con una enfermedad activa de TB. Se extiende a otra persona al toser c estornudar gérmenes de TB en el aire. Estos gérmenes pueden ser inhalados por el niño. Los adultos que tienen TB activa suelen tener muchos de los siguientes síntomas: tos por más de dos semanas de duración, pérdida de apetito, pérdida de peso de 10 o más libras durante un corto período de tiempo, fiebre, escalofríos y sudores nocturnos. Una persona puede tener gérmenes de TB en su cuerpo y no tener una enfermedad activa de TB. La TB es prevenible y tratable. El reposo cutáneo de la TB se usa para ver si su hijo ha sido infectadc con gérmenes de la TB. No se recomienda ninguna vacuna para su uso en los Estados Unidos para prevenir la TB. La prueba cutánea no es una vacuna contra la tuberculosis.

Necesitamos su ayuda para averiguar si su hijo ha estado expuesto a la tuberculosis)

We need your help to find out if your child has been exposed to TB / Cuestionario TB

Place a mark in the appropriate box. Coloque una marca en la casilla correspondiente. TB can cause fever of long duration, unexplained wt loss, a bad cough (lasting over two weeks.), or coughing up blood. (La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos seca (que dura más de dos semanas) o tos con sangre.)	Yes Si	No	Don't know No lo sé
- Has your child been around anyone with any of these symptoms or problems?- ¿Su hijo ha estado cerca de alguien con alguno de estos síntomas o problemas? -Has your child been around anyone sick with TB?-¿Tu hijo ha estado cerca de alguien enfermo de tuberculosis?			
Was your child born in Mexico?/¿Su hijo nació en México? Or any other country in Latin America, the Caribbean, Africa, Easter Europe or Asia? ¿O cualquier otro país de América Latina, el Caribe, África, Pascua Europa o Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Europe, or Asia for longer than 3 weeks? *If so, please specify which country/countries? ¿Su hijo viajó el año pasado a México oa cualquier otro país de América Latina, el Caribe, África, Europa o Asia por más de 3 semanas? * En caso afirmativo, especifique qué país / países?			
TO your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an IV drug user, HIV infected, in jail or prison or recently cam to the United States from another country? Según su conocimiento, ¿ha pasado su hijo (más de 3 semanas) con alguien que ha sido / ha sido un usuario de drogas intravenosas, infectado por el VIH, en la cárcel o en la cárcel o recientemente ha estado en Estados Unidos desde otro país?			
Has your child been tested for TB? If yes, please specify date: ¿Su hijo ha sido examinado para la TB? En caso afirmativo, sírvase especificar la fecha:			
Has your child ever had a positive TB skin test? If yes, please specify date: ¿Ha su hijo alguna vez una prueba positiva de la piel de la TB? En caso afirmativo, sírvase especificar la fecha:			

LEAD QUESTIONNAIRE / CUESTIONARIO DE PLOMO

Place a mark in the appropriate box. Coloque una marca en la casilla correspondiente.	Yes	No	
Does your child live in or visit a home, daycare or other building built before 1978?¿ Su hijo vive o visita una casa, guardería u otro edificio construido antes de 1978?			
Does your child live in or visit a home, daycare or other building with ongoing repairs or remodeling? ¿Su hijo vive o visita una casa, guardería u otro edificio con reparaciones o remodelaciones en curso?			
Does your child eat or chew on non-food things like paint chips or dirt? ¿Su niño come o mastica cosas no-alimentarias tales como virutas de pintura o suciedad?			
Does your child have a family member or friend who has or did have an elevated blood lead level? ¿Su hijo tiene un miembro de la familia o amigo que tiene o tenía un nivel elevado de plomo en la sangre?			
Is your child a newly arrived refugee or foreign adoptee? ¿Su hijo es un refugiado recién llegado o adoptado en el extranjero?			

If "Yes" or "Don't Know" was checked above, Perform a Blood Lead Test.
Si se seleccionó "Sí" o "No sabe", realice una prueba de plomo en la sangre.

M CHAT

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

M-CHAT-R™ *(Modified Checklist for Autism in Toddlers Revised)*

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	Yes	No