WELL CHILD VISIT – AGE 12 MONTHS

☐ Male ☐ Female

Name: _____ ID # _____ Age: _____ DOB: _____ ☐ **IHEBAT** ☐ **120-Day IHA**

Accompanied by: ☐ Mom ☐ Dad ☐ Relative ☐ Other: _____ **Date of Visit:**_____

Wt: lbs/oz/kg (%ile)	Ht: inches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Hgb :_____ Bld Lead Level:_____ Nurse/MA_____

HISTORY

Interim History:
- ☐ No Problems
  - ☐ Significant Illness / Injury _____
  - ☐ Medications: _____
  - ☐ Allergies: _____
  - ☐ Visits to other health care provider: (name) _____

Social / Family History:
- ☐ No interval changes
  - ☐ Divorced / Single Parent
  - ☐ Child care Type:_____

Changes since last visit:_____

Nutrition: ☐ Breast ☐ Bottle ☐ Cup
Milk _____ Oz/day _____
Solid foods _____
Juice _____
Water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____
_____

Sleep: ☐ NL _____
_____

Behavior: ☐ NL _____

Toxic exposure: Lead ☐Yes ☐No Passive Smoking ☐Yes ☐ No
TB risk: ☐ High ☐ Low

DEVELOPMENTAL HISTORY (✓ if within Normal Limits)

- ☐ Says 2-4 words / imitates vocalizations
- ☐ Points to eyes, ears
- ☐ Feeds self
- ☐ Pulls to stand, cruises & may take few steps alone
- ☐ Plays pat-a-cake, peek-a-boo
- ☐ Points / Waves "bye-bye"
- ☐ Bangs blocks together
- ☐ Drinks from a cup
- ☐ Looks for dropped or hidden objects
- ☐ Looks at pictures

PHYSICAL EXAM (✓ if within Normal Limits)

NL		Comment if Abnormal
☐	General Appearance	
☐	Skin	
☐	Head	
☐	Eyes / Appears to see	
☐	Ears / Appears to hear	
☐	Nose	
☐	Mouth and Throat	
☐	Teeth	
☐	Neck	
☐	Lungs	
☐	Heart	
☐	Femoral Pulses	
☐	Abdomen	
☐	Genitalia	
☐	Ext/Hips	
☐	Back (Scoliosis)	
☐	Neurologic	

ASSESSMENT

- ☐ Well Child

ANTICIPATORY GUIDANCE / EDUCATION (✓ if discussed or handout given)

- ☐ Healthy habits – adequate sleep, exercise, fluids
- ☐ Safe foods, snacks, healthy food choices, variable appetite
- ☐ Dental care, toothbrush
- ☐ Toilet habits
- ☐ Sleep habits, lower crib mattress
- ☐ Establish routines
- ☐ Interactive talking, singing, reading
- ☐ Exploration, physical activity
- ☐ Hitting, biting, aggressive behavior
- ☐ Self-care, self-quieting
- ☐ Toddler car seats, airbags
- ☐ Childproof home; Syrup of Ipecac, Close supervision
- ☐ Injury prevention, falls, water, burns
- ☐ Cuddling, holding, affection

REFERRALS / AUTHORIZATIONS

- ☐ WIC ☐ Vision Referral
- ☐ CCS ☐ Dental Referral
- ☐ Counseling
- ☐ Specialist (name) _____

IMMUNIZATIONS / LABORATORY

- ☐ IPV ☐ MMR ☐ PCV ☐ Hct/Hgb
- ☐ Hib ☐ VZV ☐ Hep B ☐ Lead Screen
- ☐ Other: _____ ☐ _____
- ☐ Vaccine Information Statements (VIS) given to patient
- ☐ PPD Date given:_____ Results: _____
- ☐ CXR Results: _____

Plan: 1. **NEXT VISIT AT AGE 15 Months**
2.
3.

10/03

Signature_____**MD/DO/NP/PA Date**:_____