WELL CHILD 12 months	Name: ☐ Female ☐ Male
Visit Date: ___/____/____	DOB: ____/____/____ Age: _____ months
Language: ☐ English Other:	☐ Interpreter used – Name:

T:	P:	RR:	H.C.	Height: in.	Weight: lb.	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies: **Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ breast **WIC:** ☐ Yes ☐ No

Solid foods:

Appetite: **TB risk:** ☐ No ☐ Yes

Elimination:

Sleep:

Illnesses:

Childcare:

PARENTAL CONCERNS

GROWTH and DEVELOPMENT

☐ Walks with assist	☐ 3 - 6 words
☐ Uses cup to drink	☐ Bangs blocks together
☐ Feeds self	☐ Bedtime routine

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet	☐ whole milk ☐ table food
Safety	☐ toddler car seat ☐ household safety ☐ water safety ☐ childproofing ☐ sun screen
Guidance	☐ mobility ☐ shoes ☐ temper tantrums ☐ not ready for toilet training ☐ dental care ☐ family dynamics ☐ parental time out

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Heart**	☐ regular rhythm ☐ no murmur
		Femoral pulses	☐ normal bilaterally
Head	☐ symmetrical ☐ AF open _____ cm	**Abdomen**	☐ soft, no masses ☐ liver & spleen normal
Eyes	☐ red reflex L R ☐ no strabismus ☐ vision grossly normal	**Genitalia**	☐ grossly normal
		male:	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal ☐ hearing grossly normal	**Spine**	☐ normal, no sacral dimple
		Extremities	☐ no deformities, full ROM
Nose/ mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction
Neck	☐ supple / no masses	**Skin**	☐ clear, no significant lesions
Lungs	☐ clear to auscultation bilaterally	**Neurologic**	☐ normal tone ☐ normal DTR's

Comments:

ASSESSMENT:	PLAN:

ORDERS: ☐ Vaccine reactions, risks and follow-up explained /VIS sheets given ☐ Immunization registry entry

Immunizations- ☐ Hep B ☐ DTaP *(if 6 months since previous dose)* ☐ Hib ☐ PCV ☐ IPV ☐ MMR *(12 mos)*
☐ Varicella *(@12 mos.)* ☐ Hep A *(1st dose @ 12 mos+)* ☐ Influenza *(yearly)* Other:

Fluoride - ☐ Rx. 0.25 / 0.5 mg qd - refill until age 2 ☐ Fluoride varnish

Labs: ☐ Hgb *(@ 9-12 months)* ☐ Lead *(@ 12 months)* ☐ PPD

REFERRAL: ☐ WIC ☐ Dental (at 1 year) Other: _____ ☐ PM 160 completed

Next appointment: ☐ 3 months Other: _____ **Provider Signature:** _____