



Well Child Visit: 10-12 Months



Name: _____ DOB: _____ Date: _____

Current Medications			Drug / Food Allergies			Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	HC	HR	Resp.	Temp.	Interpreter: Y / N	
Past Medical History			Interval History			Nutrition		
Recent illness: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			Sleep: <input type="checkbox"/> NL _____ <input type="checkbox"/> Back to sleep <input type="checkbox"/> Sleeps in own crib			<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Supplementing / both <input type="checkbox"/> Formula (type): _____		
Child has dental home (12 mos.): <input type="checkbox"/> Yes <input type="checkbox"/> No			Elimination: <input type="checkbox"/> NL _____			Frequency: _____		
Reaction to previous IMMS: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			Behavior: <input type="checkbox"/> NL _____			Fruits: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Vegetables: <input type="checkbox"/> Yes <input type="checkbox"/> No		
F/u previous concern: <input type="checkbox"/> None _____			Car seat rear-facing: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			Meats: <input type="checkbox"/> Yes <input type="checkbox"/> No ___ Vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Concerns: _____								
Social/ Family History				Growth-Development				
Lives at home with: _____				Cognitive: <input type="checkbox"/> NL _____		Language: <input type="checkbox"/> NL _____		
Parent / child interaction: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				• Object permanence, looks at books, knows "Peek-a-boo"		• Says 2-3 words besides "mama/dada", recognizes name, imitates some words		
Tobacco smoke exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No _____				Physical: <input type="checkbox"/> NL _____		Social: <input type="checkbox"/> NL _____		
Parents working outside home: <input type="checkbox"/> Mother <input type="checkbox"/> Father				• Crawling, pulls to standing		• Apprehensive with strangers, seeks parent for play & comfort		
Child care: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____								
Family / work balance: <input type="checkbox"/> Yes <input type="checkbox"/> No _____								
WIC: <input type="checkbox"/> Yes <input type="checkbox"/> No _____								
Parental Concerns: _____ _____ _____								
Physical Exam (checked <input type="checkbox"/> = normal)						Abnormal Findings		
<input type="checkbox"/> General (Alert, NAD)		<input type="checkbox"/> Heart (No murmurs, + femoral pulses)						
<input type="checkbox"/> Head (No deformities, symmetric)		<input type="checkbox"/> Lungs (Clear breath sounds)						
<input type="checkbox"/> Eyes (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear)		<input type="checkbox"/> Abdomen (Soft, non-tender)						
<input type="checkbox"/> Ears (Canals clear, TMs normal, orients to sounds, voice)		<input type="checkbox"/> Skin (No rashes)						
<input type="checkbox"/> Nose (Mucosa NL, septum NL, patent)		<input type="checkbox"/> Neuro (Tone, symmetry, strength all NL)						
<input type="checkbox"/> Mouth (MMM, palate intact, lips NL, tongue NL, no oral lesions, teeth:___)		<input type="checkbox"/> Extremities (Full ROM, strength/tone NL, no hip dysplasia)						
<input type="checkbox"/> Throat (No erythema)		<input type="checkbox"/> Genitalia						
		Male (Penis NL: circ/uncir, no adhesions)						
		Female (Labia/clitoris NL, no discharge)						
Assessment				Anticipatory Guidance				
<input type="checkbox"/> Well child				<input type="checkbox"/> Discipline (Limit "no", use descriptors, domestic violence)				
<input type="checkbox"/> Normal growth and development				<input type="checkbox"/> Safety (Back to sleep, car seats, avoid smoke exposure, crib safety, burns, baby-proof home, drowning, poisoning, baby gates)				
<input type="checkbox"/> IMMS UTD				<input type="checkbox"/> Nutrition (Self-feeding, mealtime routines, table foods, use of cup)				
<input type="checkbox"/> IMMs due _____				<input type="checkbox"/> Oral Health (Fluoride, wash gums with warm washcloth, teething)				
				<input type="checkbox"/> Development (Sleep schedule, object permanence, separation anxiety, temperament, communication, read to baby, visual exploration)				
Plan								
<input type="checkbox"/> Lead screening #1								
<input type="checkbox"/> Dental fluoride varnish every 3-6 mos. either primary care or dental office								
<input type="checkbox"/> Fluoride supplementation risk assessment								
<input type="checkbox"/> Iron Deficiency Anemia screening to be completed at (12 mos.)								
<input type="checkbox"/> TB testing based on risk factors (12 mos.)								
<input type="checkbox"/> Immunizations (See immunization record)								
<input type="checkbox"/> Education handout given								

Next Appointment: _____ Signature: _____ Date: _____

