



12 Months up to 18 Month Child Health History & Physical Check-up

PLEASE PRINT

PERSONAL: Well child visit Parent/Caregiver Request

ALLERGIES	DATE	AGE	SEX	ACCOMPANIED BY	RELATIONSHIP
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CHILD INTERVAL HISTORY:

MEDICAL HISTORY (any changes or concerns since last visit) <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
FAMILY MEDICAL HISTORY (any changes or concerns since last visit) <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
ANY ILLNESSES, ACCIDENTS OR HOSPITALIZATIONS: <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
DENTAL HISTORY/ ISSUES: <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
DEVELOPMENTAL ISSUES: <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
BEHAVIORAL ISSUES: <input type="checkbox"/> NO <input type="checkbox"/> YES (DESCRIBE)	
CURRENT MEDS:	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON

DEVELOPMENTAL ASSESSMENT:

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (Does this client play pat-a-cake, use pincer grasp, stands momentarily, walks holding on, points by 12 mos.; Uses spoon, kicks/throws ball, walks alone, move to music, drop & pick-up toys, responds to "no" by 18 mos.)	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED Formalized Screening tool _____ Results _____	

NUTRITIONAL ASSESSMENT

Is this a WIC participant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred					
Is your home on: <input type="checkbox"/> well water <input type="checkbox"/> city water		Is city water fluoridated? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW		Age when weaned from breastfeeding: _____ Age when weaned from bottle: _____	
Breast milk <input type="checkbox"/> Exclusively <input type="checkbox"/> Partially	# Of Wet Diapers/ Day	# Of Soiled Diapers/ Day	Consistency <input type="checkbox"/> LIQUID <input type="checkbox"/> SEEDY <input type="checkbox"/> SOFTLY FORMED <input type="checkbox"/> HARD FORMED	<input type="checkbox"/> FORMULA: _____ Amount per feeding: /Frequency:	Diet Adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequency: Length of feedings:		Stool Color			
What other beverages does this child drink? (check all that apply):					
<input type="checkbox"/> Soy milk <input type="checkbox"/> Whole milk <input type="checkbox"/> 2% reduced fat milk <input type="checkbox"/> 1% low fat milk <input type="checkbox"/> fat free milk <input type="checkbox"/> tea <input type="checkbox"/> Water with sugar <input type="checkbox"/> Water <input type="checkbox"/> Bottled Water <input type="checkbox"/> 100% fruit juice <input type="checkbox"/> Gatorade <input type="checkbox"/> Fruit drinks <input type="checkbox"/> soda Nutrition supplements _____ <input type="checkbox"/> other _____					

How often does the child eat these foods?

Meat, poultry, fish, beans, or eggs <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Milk, yogurt, or cheese <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Vegetables <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never
Fruits <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Grains – breads, cereal, rice, or pasta <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never	Cookies, cakes, pies, candy <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never
Fried foods, French fries, sausage, hot dogs, bacon <input type="checkbox"/> daily <input type="checkbox"/> some days <input type="checkbox"/> never		

LAB TESTS: Previously Screened

<input type="checkbox"/> LEAD RISK ASSESSMENT (@ 1 mo.-6 yrs., if pos do blood test)	<input type="checkbox"/> BLOOD LEAD TESTING (@ 12 & 24 mo; @ 36-72 mo, if not previously screened.)	<input type="checkbox"/> TB SCREEN/PPD RESULTS _____	<input type="checkbox"/> SICKLE CELL SCREENING	<input type="checkbox"/> Hgb/Hct _____ (15-18 mos)	<input type="checkbox"/> OTHER (Specify, as indicated)
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Signature/Title _____ Date _____

Signature/Title _____ Date _____

Label



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PHYSICAL EXAM

TEMP:	PULSE:	RESPIRATIONS:	LENGTH:	WEIGHT:	HEAD CIRCUMFERENCE:	CHEST CIRCUMFERENCE:
Type:			Percentile:	Percentile:	Percentile:	Percentile:

Check as appropriate <input checked="" type="checkbox"/>	N	A	N=Normal A=Abnormal	COMMENTS
1. Appearance				
2. Skin				
3. Head				
4. Eyes				
5. Ears				
6. Nose				
7. Mouth/Throat				
8. Teeth/Gums				
9. Nodes				
10. Heart				
11. Lungs				
12. Abdomen/Umbilicus				
13. Femoral Pulse				
14. External Genitalia				
15. Hip Exam				
16. Extremities				
17. Spine				
18. Neurological				
19. Other				

SENSORY SCREEN: VISION: (red reflex, Follows, cover-uncover) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED	HEARING: (by 12 mo. Responds to "no", follows simple commands, gives objects upon request, 1-3 words; by 18 mo. Reacts to music, points to named objects, 2-3 word other than mama-dada, points to named body part) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> REFERRED
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IMMUNIZATIONS PLAN: DUE TODAY _____ ADMINISTERED DEFERRED/PARENT DECLINED NONE DUE

HEALTH EDUCATION, ANTICIPATORY GUIDANCE:

<input type="checkbox"/> CAR/ BOOSTER SEAT	<input type="checkbox"/> SAFETY- HOME/ POOL/ FALLS	<input type="checkbox"/> SLEEPING/ CRIB	<input type="checkbox"/> DAYCARE	<input type="checkbox"/> TOILET TRAINING
<input type="checkbox"/> TEETHING	<input type="checkbox"/> FEVER EDUCATION	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> NO BOTTLE IN BED	<input type="checkbox"/> SOLID FOODS
<input type="checkbox"/> CUP, FINGER FOODS	<input type="checkbox"/> NUTRITION / SNACKS	<input type="checkbox"/> SELF FEEDING	<input type="checkbox"/> CHOKING, ASPIRATION	<input type="checkbox"/> READ TO CHILD
<input type="checkbox"/> PETS IN HOME	<input type="checkbox"/> SIBLING INTERACTION	<input type="checkbox"/> TANTRUMS	<input type="checkbox"/> TALK & NAME OBJECTS	<input type="checkbox"/> POISONS
<input type="checkbox"/> LEAD EXPOSURE	<input type="checkbox"/> DISCIPLINE/LIMITS & PRAISE	<input type="checkbox"/> 2 ND HAND SMOKE	<input type="checkbox"/> SKIN CARE /SUN PROTECTION	
<input type="checkbox"/> DOMESTIC VIOLENCE	<input type="checkbox"/> SHAKEN BABY SYNDROME	<input type="checkbox"/> FIREARMS IN HOME	<input type="checkbox"/> POST PARTUM DEPRESSION	
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> LITERATURE GIVEN _____			

ASSESSMENT/DIAGNOSIS:	PLAN/ORDERS/REFERRAL:
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RETURN APPT: _____	ORDERS REVIEWED BY: _____
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Signature/Title _____ Date _____	Label
Signature/Title _____ Date _____	