Well Child Care 12 months

Name : DOB: Date:

Do you have any concerns today ? □ No Yes_____

Nutrition/Review of systems	yes	no	Review of systems/symptoms	yes	no
Breast feeding ?			Any Vision Problems?		
Bottle feeding ?			Any hearing problems?		
Eating solids ? if yes, eats vegetables ,fruits, meat, fish ? (circle)			Any breathing problems ?		
Spits up ? if yes, is spitting up forceful ?			Any skin problems?		
Drinks milk? _____oz/day			Any heart problems ?		
Drinks juice ? _____oz/day			Any sleep concerns?		
Bowel movements normal ?			Any past bad reactions from immunizations ?		
Has hard stool /cries with bowel movements ?			Any lead poisoning risks?		
Immunizations up to date?			Any TB Exposure?		
Oral Health risk Assessment:					
Mother/ primary caregiver had active tooth decay in past 12 mo			Mother or primary caregiver has a dentist ?		
Frequent snacking ?			Bottle/ sippy cup use with fluids other than water ?		
Special health care needs child?			Child has a dentist ?		
Medicaid eligible ?			Water supply □ city □ well □ drink bottled water		
Has teeth brushed twice daily?			Any dental Concerns?		
Developmental Questions : Does your baby					
Meaningfully uses mama or dada?			Respond to simple command e.g. " come here"		
Produce long strings of gibberish (jargoning)?			Release objects into a container with a large opening?		
Turn head in the direction from where a sound is made?			Use thumb and pointer finger to pick up tiny objects?		
Pull up to stand?			Finger feeds to self?		
Walk holding on to furniture or independently ?			Copy behaviors like using a cup or telephone?		
Play peek-a-boo?			Any concerns about your baby's development?		
Safety/anticipatory guidance issues:					
Family violence & substance abuse? circle			Using rear facing car seat?		
Exposed to passive smoking?			Fall, Fire and Burn precaution in place ?		
Home swimming pool ?			Medication, personal hygiene products, alcohol, cleaning supplies ,trash containers out of reach?		
Family history:					
High cholesterol ,Triglycerides			Obesity		
Diabetes			Early Heart disease ,Hypertension		

Anticipatory guidance: *□ discussed and /or handout given.*

Family Support: *□time for self & partner □community activities □age appropriate discipline .* ***Establishing routines:*** *□ family traditions □ nap and bedtime.*

Feeding and appetite changes: *□self-feeding □consistent meals/snacks □variety of nutritious foods □ Limit milk intake to 24 oz/day or less for children 1-5 yrs. □ Limit juice and other sweetened drinks 4-6 oz/day.*

Establishing dental home: *□first dentist visit □brush teeth twice daily□ limit bottle use (water only) □no bottle in bed .*

Safety: *□ Use rear facing car seat until age 2 and weight 35 lbs. □ Choking hazards: foods (hot dogs, hard candy, nuts, popcorn, chunks of meat, vegetables etc) and small objects (coins, balloons, button batteries, marbles, small toys or parts etc). □ water safety □sharp objects □ no supervision by young children.*

Immunization: *□ Risks, benefits, side effects, alternative □ refused, vaccine refusal form signed.*

Signature of parent/guardian: **Provider Signature:**