

Patient Name:

FMP and Sponsor SSN last four:

Date of visit: Date of Birth:

12 - 23 MONTH WELL VISIT

Do you have any specific concerns today? _____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
		Allergies Asthma Other:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):

Please list any known allergies your child has (drug, food, latex) _____ No Allergies

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness before age 5 Birth Defects Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? Yes No

Is the child's sponsor currently deployed? Yes No Is this visit deployment related? Yes No

Source of Medical Information: Mother Father Other: _____

Are your child's immunizations up to date? Yes No Unsure

Who does your child live with? _____

Does your child attend daycare? Yes No

Does anyone in the family smoke or is your child exposed to secondhand smoke? Yes No

Are the instructions for Patient Understood by Caregiver/Patient? Yes No

Do you & your child feel safe at home? Yes No

What is your preferred method for learning: Verbal Written Other: _____

Preferred language: English Other: _____

Are there cultural or religious considerations that affect your child's healthcare? No Yes _____

Please provide a good contact phone number: _____

-----Additional Hx/Prevention-----

Breastfeeding? Yes No Ounces per day: _____

Formula feeding? Yes No Ounces per day: _____

Drink whole milk? Yes No Ounces per day: _____ Drink juice? Yes No Ounces per day: _____

Good variety of table foods? Yes No

Number of wet diapers per day? _____

Circle if you have concerns about: Bowel movements Constipation Sleep problems

Does either parent have: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? Yes No

Does your child have a high lead risk (based on 6 questions on wall of the exam room)? Yes No

-----Development/Behavior-----

In the age group below that is closest to your child's age, please check the actions your child does:

12 MONTHS	18 MONTHS
<input type="checkbox"/> Babbles	<input type="checkbox"/> Points to body part on request
<input type="checkbox"/> Plays peek-a-boo	<input type="checkbox"/> Drinks with the minimal spilling
<input type="checkbox"/> Pulls self to a standing position	<input type="checkbox"/> Stacks two blocks
<input type="checkbox"/> Waves bye-bye	<input type="checkbox"/> Helps with simple tasks
<input type="checkbox"/> Imitates simple daily tasks	<input type="checkbox"/> Uses spoon with the minimal spilling
<input type="checkbox"/> Offers a book to read	<input type="checkbox"/> Names favorite book
<input type="checkbox"/> Drinks from a cup	<input type="checkbox"/> Laughs in response to others
<input type="checkbox"/> Imitates sounds	<input type="checkbox"/> Vocabulary of 7-20 words
<input type="checkbox"/> Follows gaze	<input type="checkbox"/> Runs
<input type="checkbox"/> Cries when you leave	

<input type="checkbox"/> Stands well alone	
<input type="checkbox"/> Bangs objects together	
<input type="checkbox"/> Says Mama or Dada specifically	

Weight		HR		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  Technician Signature: _____ Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/>
Length		RR		
OFC				

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/Nontender/FROM	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, no lumbosacral pits	<input type="checkbox"/>
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/>
<input type="checkbox"/>	Hips:	<input type="checkbox"/> Full ROM, Symmetric leg folds	<input type="checkbox"/>
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down	
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: H&H (12 months): Lead Screening (if applicable)

ASSESSMENT: Well baby: normal growth & development for age
 ASQ performed: normal development in all areas
 M-CHAT performed (at 18-23 months): normal

PLAN: Fluoride supplementation (as needed locally)
 Immunizations per clinic schedule

F/U: at next well child visit at ___ months, sooner if parental concerns
 Patient and/or parent verbalizes understanding of treatment and plan Anticipatory guidance handout provided

PREVENTION: Nutrition Sippy Cups/No Bottle Dental care Safety/Falls Car Seat Child-proofing the house
 Tobacco avoidance

Signature: _____ **Date:** _____
Stamp:

RECORDS MAINTAINED AT: 		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH