Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

12 - 23 MONTH WELL VISIT

Do you have any specific concerns today? _____

_____

_____

Any recent ER visits? ❑Yes ❑ No **When:** _____ **Reason:**_____

*****(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):**

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

Please list any known allergies your child has (drug, food, latex) _____

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

Is either of the child's parents on PRP status? ❑Yes ❑ No

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? ❑ Yes ❑ No

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

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

Preferred language: ❑ English ❑ Other: _____

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

Diet History:

Breastfeeding? ❑ Yes ❑ No How often? _____ Minutes per breast?_____ Concerns?_____

Bottle feeding? ❑ Yes ❑ No Brand? _____ Ounces per feed? _____ Ounces per day? _____

Drink whole milk? ❑ Yes ❑ No How many ounces per day? ____

Drink juice? ❑ Yes ❑ No How many ounces per day? _____

Good variety of table foods? ❑ Yes ❑ No

Number of wet diapers per day? _____ **Stools per day?** _____

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems / Vision / Hearing

In the age group below that is closest to your child's age, please check the items your child is able to perform:

12 MONTHS	15 MONTHS	18 MONTHS
❑ Says "Mama" and "Dada"	❑ Has "Mama", "Dada" and 3 extra words	❑ Has 3-10 words
❑ 3 words other than mama/dada	❑ Follows simple commands	❑ Says 2-3 word sentences
❑ Points at objects to show you	❑ Listens to you read a book to them	❑ Points to a body part
❑ Imitates simple tasks	❑ Imitates simple tasks	❑ Turns single pages in a book
❑ Grabs small objects with tip of finger and thumb	❑ Points at objects to ask for them	❑ Stacks 5 or more blocks
	❑ Walks well, stoops and climbs stairs	❑ Takes off their own clothes
❑ Waves Bye-Bye	❑ Stacks 2 blocks	❑ Runs well
❑ Stands well alone	❑ Scribbles	❑ Kicks a ball forward
❑ Walks holding onto furniture	❑ Drinks from a cup / Feeds self	❑ Walks up stairs
❑ Bangs things together	❑ Walks without help	❑ Scribbles
		❑ Uses a spoon

Weight		Pain: ❑ Yes ❑ No Location of Pain _____
Length		
OFC		Technician Signature:_____
		Imm UTD per ASIMS: ❑ Yes ❑No

HPI:

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

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:

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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

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