VACCINES: P C

WELL CHILD 12 MONTHS

Today's Date:_____

Patient Name:_____ Date of Birth:_____

FAMILY HEALTH CENTER OF MISSION

FAMILY HISTORY:
Changes in household since last visit ___Yes/No Explain_____
Child Lives with: ___Mother ___Father ___Grandparent ___Stepparent ___Other_____
Primary Caregiver: ___Mother ___Father ___Grandparent ___Daycare ___Other_____

NUTRITION:
1. Does your child have any recurrent problems with feeding? __No __Yes
   Child has the following problems: (circle) Persistent spitting up, vomiting, poor feeding, stomach problems
   Other:_____
2. How often does your child feed?_____
   Breast-fed: Number of feedings in 24 hrs_____ Length of feedings: _____(minutes)
   Formula-fed: Type: _____Ounces:_____ Every: _____hours Fortified with iron _____Yes/No
3. Are you giving your child any solid foods? ____Yes/No List_____
4. Does your child receive any supplements: ____fluoride ____iron ____vitamins

CHILD HEALTH: Indicate Yes or No and Check ☑ any that apply.
1. Does your child have any food or drug allergie s? ___ Yes/No List_____
2. Has your child had any major illness, surgeries, injuries or hospitalizations? _____Yes/No
   List:_____
3. Does your child have any physical problems? ____Yes/No Such as: ___Low Weight Gain ___Weight Loss ___ Vomits
   ___Problems Eating ___Listlessness ___Sleeping Problems ___Other_____
4. Does your child take any medications regularly? _____Yes/No _____

IMMUNIZATIONS: Check ☑ Yes or No
___**Yes** ___**NO** Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY: Indicate Yes or No
Vision Screen:
1. Does your child seem to see well? _____Yes/No
2. Do your child's eyes appear to cross, drift or seem lazy? ___Yes/No Explain_____
3. Do your child's eyes appear unusual? ___Yes/No Explain_____

Hearing Screen:
1. Does your child give you toys or objects when you ask for them without using a gesture? _____Yes/No
2. Does your child point to familiar objects when asked? _____Yes/No

DEVELOPMENT: Indicate Yes or No
1. Begins to use objects correctly, such as drinking from a cup _____Yes/No
2. Bangs 2 objects together _____Yes/No
3. Uses one or 2 verbal labels for objects/people _____Yes/No
4. Stands alone for 2 seconds _____Yes/No

MENTAL HEALTH: Check ☑ any that apply.
Feelings: ___Appropriate for age ___Cries Excessively ___Cries too little ___Irritable
Social Interaction: Responds to loud noises ___Yes/No Responds to voices ___Yes/No
Thinking: ___Appropriate for age ___ Poor attention span
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ____Yes/No
Explain: _____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check ☐ if no problems are noted.
Skin: ___rashes ___infections
Eyes: ___Eye Discharge ___Deviation ___Excessive Tearing
Ears: ___Hearing problems ___Ear problems
Nose/Mouth/Throat: ___Nasal Congestion ___Nasal Discharge ___Sore throat
Cardio: ___History of murmur
Respiratory: ___Trouble Breathing ___Wheezing
Gastrointestinal: ___Frequent Bowel Movements ____Vomiting
Genitourinary: ____Abnormal Appearance
Neuromuscular: ____Seizures ____uncoordinated movements
Musculoskeletal: ____Fractures ____Deformity

Form Complete:_____(staff initials)

WELL CHILD 12 MONTHS Today's Date:_____

Patient Name:_____ Date of Birth:_____

Weight:_____ Height:_____ OFC:_____ Temp:_____
(%)_____ (%)_____ (%)_____

FOR OFFICE USE ONLY

PHYSICAL EXAM:	**Normal**	**Abnormal**	**Comments**
Appearance	_____	_____	_____
Head/fontanels	_____	_____	_____
Skin/nodes	_____	_____	_____
Eyes	_____	_____	_____
Symmetric Corneal light reflex	_____	_____	_____
Conjugate gaze bilaterally	_____	_____	_____
Red Reflex present bilaterally	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth/Throat	_____	_____	_____
Teeth	_____	_____	_____
Neck	_____	_____	_____
Chest/breasts	_____	_____	_____
Heart/Pulses	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia/anus	_____	_____	_____
Spine/Hips	_____	_____	_____
Extremities	_____	_____	_____
Muscle Tone	_____	_____	_____
DTRs	_____	_____	_____

ASSESSMENT: **1.** Well Child 12 Months Old 2._____

3. _____ 4. _____

PLAN:

Immunizations: ___Hep B # 3 ___Hib # 4 ___IPV # 3 ___ MMR # 1 ___Prevnar # 4 ___Varicella ___Influenza
___**PPD (Medicaid Required)** ___DTaP # 4 ___Proquad (MMR 1+Varicella) ___Hep A # 1
___Parent declines vaccines: (List)_____

Lab Work Required for Medicaid: ___**Lead** ___**Hct/Hgb** **Parent declines test:** ___**Lead** ___**Hct/Hgb**
___ Hep C (if 12 months old or older and born to HCV infected woman)_____

EPSDT Questionnaires: ___Lead Questionnaire given ___TB Questionnaire given

Referral made to: _____

Health Education Handout Given to Parent/Guardian _____

RTC in : _____months/prn _____yr/prn

Document in Document1 11/16/06 9/3/09 9/23/09 12/6/2010 4/30/12 8/6/14