PEDIATRIC VISIT 12 to 14 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated?_____
Family health history updated?_____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: Child care:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No_____
Evidence of neglect or abuse? Yes / No_____

RISK ASSESSMENT:

(Circle)	TB	LEAD
	Pos / Neg	Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Dental/Number of teeth
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

_____

NUTRITIONAL ASSESSMENT:

Typical diet: *(specify foods)*:

Education: Phase out bottle ☐ Table foods ☐ Vitamins ☐
Decreased appetite ☐ Whole milk until age two ☐
Keep offering new foods ☐ Nutritious snacks ☐

DEVELOPMENTAL SCREENING: *(With Standardized Tool)*

ASQ: ☐ PEDs ☐ Other: ☐ *(specify)* _____
Results: Wnl ☐ Areas of Concern:_____
Referred: Yes / No Where? _____

DEVELOPMENTAL SURVEILLANCE: *(Observed or Reported)*

Social: Fear of strangers ☐ Separation anxiety ☐

Fine Motor: Scribbles ☐ Pincer grasp ☐ Drinks from cup ☐

Language: Dada or Mama (specific) ☐ 1 to 3 words ☐
Indicates wants ☐

Gross Motor: Stands alone ☐ "Cruises" ☐ Walks ☐ Stoops and recovers ☐ Plays ball with examiner ☐

ANTICIPATORY GUIDANCE:

Social: Fear of strangers ☐ Separation anxiety ☐

Parenting: Delay toilet training ☐ Negativism ☐ Autonomy ☐
Discipline means to teach ☐ Avoid spanking/slapping ☐

Play and communication: Varied activities ☐
Singing, naming, reading ☐

Health: Fever ☐ Fluoride if well water ☐ Brush teeth ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Poison control # ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don't leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Lead test/HCT required ☐ _____
3. PPD, if positive risk assessment ☐ _____
4. Has parent renewed MA for infant? ☐
5. Dental visit advised ☐_____
6. Fluoride Varnish Applied? Yes / No_____
7. Next preventive appointment at 15 months ☐ _____
8. Referrals for identified problems? *(specify)*_____

_____

_____

_____

_____

Signatures:_____