WELL CHILD ASSESSMENT 10 TO 12 MONTHS

AGE:	WEIGHT:	LENGTH:	HEAD CIRC:	
TEMP:	PULSE	RESP.		MA Signature:

INTERVAL HISTORY

Diet:

Illness:

Problems:

Immunization Reaction:

Parental Concerns:

DEVELOPMENT ☐ NORMAL ☐ ABNORMAL

- ☐ Stands Momentarily
- ☐ Walks Holding Furniture
- ☐ Bangs Objects
- ☐ "MaMa", "DaDa" (now specific)
- ☐ Thumb-Finger Grasp
- ☐ Holds Cup to Drink
- ☐ Looks for Falling Object
- ☐ Plays Pat-a-Cake/Waves Bye-Bye, Understands No

PHYSICAL EXAMINATION PM 160 ☐Yes ☐No

	N	AB	ABNORMALITIES/COMMENTS
General Appearance			
Nutrition			
Skin			
Head, Neck & Nodes			
Eyes/ Eq Reflex			
ENT/Hearing			
Mouth/Dental"			
Heart			
Abdomen			
Ext. Genitalia			
Back			
Extremities/Hips			
Neurological			
Fem. Pulses			

EDUCATION (Circle Items Discussed)

Nutrition: Breast/Formula, Solids, Finger Foods, Cup, No Honey or Corn Syrup

Tobacco: Second-Hand Smoke

Safety: Nuts, Candy or Popcorn, Outlets, Stairs, Hot Water, Pools, Car Seats, Syrup of Ipecac, Lead Pottery, Folk Remedies

Parenting: Child Proof Home, Drowning, Negativism, Discipline, No Shaking,

Dental: Tooth Brushing/Avoid Sweets, Bottle Caries

☐ Growing Up Healthy Brochure given

TB RISK ASSESSMENT ☐No Risk ☐Risk

ASSESSMENT:

PLAN

☐ Blood Lead Test ☐ Hepatitis B #3 ☐ Hib #4

☐ IPV #3 ☐ MMR #1 ☐Varicella

☐ Prevnar Catch-Up #2

Next Visit:

TOBACCO ASSESSMENT

1. Patient is exposed to Passive (second-hand) Tobacco Smoke. ☐Yes ☐No
2. Tobacco Used by Patient. ☐Yes ☐No
3. Counseled about/Referred for Tobacco Use Prevention/Cessation. ☐Yes ☐No

Patient Name/ID Number:

Exam Date: ____________________

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Provider Signature