

Name _____ FMP/SSN last four: _____ DOB: _____

Email Address : _____ Contact Phone Number: _____

12 - 23 MONTH 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) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies	Example circumcision		Allergies	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements): <input type="checkbox"/> Infant Multivitamin 1 ml per day
Asthma			Asthma	
Premie			Diabetes	
Overweight			Heart Disease	
Chronic ear infections			Obesity	
Other: (reflux)				

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

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 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 _____

Please See Reverse Side

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

Ethnic Origin Filipino Hispanic Asian/Pacific Islander Southeast Asian Other Unknown Decline to Respond

Race Asian/Pacific Islander African American Caucasian Western Indian Other Unknown Decline to Respond

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

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

In the past week, has your child had:

Fever Yes/No Duration? _____ Cough Yes/No Duration? _____

Headache Yes/No Duration? _____ Wheezing Yes/No Duration? _____

Congestion Yes/No Duration? _____ Vomiting Yes/No Duration? _____

Runny nose Yes/No Duration? _____ Diarrhea Yes/No Duration? _____

Earache Yes/No Duration? _____ Abdominal pain Yes/No Duration? _____

Pulling at ears Yes/No Duration? _____ Appetite Less Yes/No Duration? _____

Eye discharge Yes/No Duration? _____ Rash Yes/No Duration? _____

Sore throat Yes/No Duration? _____ Other (describe) _____

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child:

12 MONTHS	15 -18 MONTHS	24 MONTHS
<input type="checkbox"/> Says "Mama" and "Dada"	<input type="checkbox"/> Has 3-10 words	<input type="checkbox"/> Uses 50 words or more
<input type="checkbox"/> 3 words other than mama/dada	<input type="checkbox"/> Follows simple commands	<input type="checkbox"/> Says 2-3 word sentences
<input type="checkbox"/> Points at objects to show you	<input type="checkbox"/> Listens to you read a book to them	<input type="checkbox"/> Turns single pages in a book
<input type="checkbox"/> Imitates simple tasks	<input type="checkbox"/> Points to a body part	<input type="checkbox"/> Stacks 5 or more blocks
<input type="checkbox"/> Grabs small objects with finger and thumb	<input type="checkbox"/> Points at objects to ask for them	<input type="checkbox"/> Takes off their own clothes
	<input type="checkbox"/> Walks without help	<input type="checkbox"/> Runs well
<input type="checkbox"/> Waves Bye-Bye	<input type="checkbox"/> Walks well, stoops and climbs stairs	<input type="checkbox"/> Kicks a ball forward
<input type="checkbox"/> Stands well alone	<input type="checkbox"/> Stacks 2 blocks	<input type="checkbox"/> Walks up stairs
<input type="checkbox"/> Walks holding onto furniture	<input type="checkbox"/> Scribbles	
<input type="checkbox"/> Bangs things together	<input type="checkbox"/> Drinks from a cup / Feeds self	

Lead Screening:

Does your child have a sibling/playmate with lead poisoning?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child live in/visit a house/daycare built:	Before 1978 with chipping/peeling paint?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Before 1950?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Before 1978 undergoing renovations?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE GIVE THIS FORM TO YOUR PROVIDER'S ASSISTANT

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

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