12 MONTH WELL CHILD VISIT

Hirsch Holistic Family Medicine
3525 Ensign Rd NE Ste N
Olympia WA 98506
(360) 464-9965 / (800) 897-8320 fax

Patient name: _______________________________ Date__________Age____
Accompanied by: ___________________________ Birthdate______________

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

Yes o No o Overall, I feel confident that my baby is doing well
Yes o No o I have enough help with the baby
Who lives with you and the baby? ______________________
____
No o Yes o Parenting is harder than I thought it would be
No o Yes o My baby attends daycare. How many days a week? __________

____
____

FEEDING

No o Yes o I have questions about my baby's feeding
My baby takes breast milk ______times per day, and/or
__________________ Formula ___ oz ___times per day.
No o Yes o My baby drinks juice ___oz per day.
Yes o No o My baby eats solid food ____meals per day. ___fruit
___vegetables ___meat ___dessert ___finger foods.
No o Yes o My baby has a bottle at bedtime.
No o Yes o I have questions about teething

____

SLEEPING / VOIDING AND STOOLING

Yes o No o I am satisfied with my baby's sleep schedule
naps per day____ # hours of sleep at night ____________
How do you get your baby to sleep?
Feeding / Rocking / Pacifier / Self / Other __________
No o Yes o My baby wakes up in the middle of the night. To get my baby back to sleep I ______________________________
No o Yes o My baby pees and poops normally
Wet diapers______ Stool diapers_______ per day

____
____

BEHAVIOR AND DEVELOPMENT

No o Yes o I have questions about my baby's development
Yes o No o My baby seems to see and hear well
Yes o No o My baby imitates speech and can say at least one word
Yes o No o My baby sits up alone/stands holding on/crawls
Yes o No o My baby can walk
Yes o No o My baby uses his/her finger and thumb to pick up things.
No o Yes o I have questions about discipline

____
____

PREVENTION

No o Yes o My baby lives with someone who smokes cigarettes
No o Yes o My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa.
No o Yes o I have a family member who has had Tuberculosis
Yes o No o My baby always rides in a car seat in the back seat
Yes o No o My baby is never left alone in the car or house
Yes o No o All poisons/sharp objects are locked/out of reach in our home
Yes o No o Our light sockets are covered
Yes o No o We have gates in front of stairs
Yes o No o My baby wears flame retardant pajamas
No o Yes o I have concerns about my baby's safety at home or daycare
Yes o No o Are there any other issues you want to discuss today?

____

DISCUSSION TOPICS

General questions
Family Support
Anticipate colds and viruses
Infant temperament
Childcare arrangements

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Continue breastfeeding
Encourage use of cup
Wean from formula to whole milk until age 2
Encourage table foods and self-feeding
Brushing teeth
First dentist visit

*****

Need for bedtime routine
Avoid bottle at bedtime

Normal variation
Change in stools with solids

*****

R-PDQ if concerns
Key social milestone
Increased mobility/exploring
Social games/peek-a-boo
Talk to, sing to, read to
Tantrums
Can't remember "no"
Redirect
Separation/stranger anxiety

*****

Risk of tobacco exposure
Assess TB risk

Car seat rear facing until at least 20lbs and 1 year old
Poison control 800-222-1222
Choking hazards
Burn prevention
Water safety

Mortality Leaders: Accidental injuries due to falls, drowning, burns, choking, auto accidents

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PHYSICAL EXAM: (*All items examined unless crossed out. Abnormalities circled and commented on)*

Height:__________ cm (%) T:__________
Weight:__________ kg (%) P:______
OFC: __________ cm (%) RR:____

General Appearance:	Alert, no apparent distress, social	______
Skin:	No lesions	______
Head/Fontanelles	Normocephalic, AF_____x_______	______
EENT:	Conjunctiva clear, TMs pearly,	______
	nares clear, normal oropharynx,	______
	teeth w/o carries, cover test nl	______
Lungs:	Clear	______
CV:	Normal S1, S2, RRR without murmur	______
	normal femoral pulses	______
Abdomen:	Soft, no hepatosplenomegaly or masses	______
Extremities:	Symmetric, no deformities	______
Hips:	Negative Barlow/Ortolani, ≥ 60° abduction	______
Genitourinary:	Male: testes descended,	______
	circumcised/uncircumcised	______
	Female: normal external genitalia	______
Neurologic:	Moves all extremities equally,	______
	normal tone	______

ASSESSMENT:	**PLAN:**
1. Normal developmental progress o Normal for age o Concerns ______	______ ______
2. Immunizations	o Discussed recommended schedules, risks and benefits. o DtaP #___ o Prevnar #___ o MMR #_1_ o Hep B #___ o IPV #___ o ______ o Varicella o Hib #___
3. Dental Health o Good o At risk o Caries	o Reviewed preventive measures o Fluoride 0.25 mg/day o ABCD referral
4. Tobacco Smoke Exposure o Yes o No	o Cessation counseling o Exposure avoidance o Referral ______
5. Screening Other: (safety, anemia, family, TB, Hep B, Vit D) o No risk factors identified o Risk factors ______	o Hct o Lead level (if at high risk) o PPD o ______ o Vit D Supplement
6. ______	6. ______ ______
7. ______	7. ______ ______

Next visit at 15 - 18 Months

o Problem list updated o Allergies updated
o Med list updated o See dictated note

Mortality Leaders: Accidental injuries due to falls, drowning, burns, choking, auto accidents

______ ______ ______
Provider Signature Date Preceptor Signature