

**PEDIATRIC VISIT 12 to 14 MONTHS**

DATE OF SERVICE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ / \_\_\_\_\_ % HEIGHT \_\_\_\_\_ / \_\_\_\_\_ % HC \_\_\_\_\_ / \_\_\_\_\_ % TEMP \_\_\_\_\_

**HISTORY REVIEW/UPDATE:** *(note changes)*

Family health history \_\_\_\_\_

Medical history \_\_\_\_\_

Reactions to immunizations?

**PSYCHOSOCIAL ASSESSMENT:**

Sleep:

Recent changes in family?: *(circle all that apply)*

New members, separation, chronic illness, death, recent move,

Loss of job, other \_\_\_\_\_

Child care:

Violence Assessment:

History of injuries, accidents?

Evidence of neglect or abuse?

**RISK ASSESSMENT: TB**

**LEAD**

(Circle)

Pos/Neg

Pos/Neg

**PHYSICAL EXAMINATION**

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose/Mouth/Dental
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	_____

**NUTRITIONAL ASSESSMENT:**

Typical diet:

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

**DEVELOPMENTAL ASSESSMENT:**

**(O=Observe, R=Report)**

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\_\_\_\_ Second hand  
smoke\_\_\_\_ Brush teeth\_\_\_\_ Use sunscreen\_\_\_\_

Injury prevention: Infant car seat \_\_\_\_ Rear riding seat \_\_\_\_

Smoke detector/escape plan \_\_\_\_ Hot liquids\_\_\_\_

Hot water temp. \_\_\_\_ Poison control no. \_\_\_\_

Choking/suffocation \_\_\_\_ Firearms (owner risk/safe  
storage) \_\_\_\_ Fall prevention (heights)\_\_\_\_ Water

safety (tub, pool)\_\_\_\_ Baby proof home\_\_\_\_ Don't leave  
unattended \_\_\_\_

**PLANS**

1. Immunizations by schedule
2. Lead test/HCT required
3. PPD, if risk assessment positive
4. Return visit \_\_\_\_\_

Signatures: \_\_\_\_\_