

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:

TB

LEAD

(Circle)

Pos / Neg

Pos / Neg

PHYSICAL EXAMINATION

Wnl	Abn	<i>(describe abnormalities)</i>
<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
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Dental/Number of teeth
<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 <i>(gross assessment)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing <i>(gross assessment)</i>

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 120° 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. Fluoride Varnish Applied? Yes / No _____
6. Next preventive appointment at 15 months _____
7. Referrals for identified problems? *(specify)* _____

Signatures: _____