

# Well Child Exam

Infancy: 12 months



# 12 months

Date									
Patient Name				DOB		Sex		Parent Name	
Allergies					Current Medications				
Prenatal / Family History							Ethnicity		
Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

<b>Interval History</b> (include injury/illness, visits to other health care providers, changes in family or home) _____ _____
<b>Nutrition</b> <input type="checkbox"/> Breast every _____ hours <input type="checkbox"/> Formula _____ oz. every _____ hours With iron Y <input type="checkbox"/> N <input type="checkbox"/> Type or brand _____ <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Fluoride Rx
<b>Elimination</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Sleep</b> <input type="checkbox"/> Normal (8-12 hours) <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page
<b>Screening</b> <b>Hearing</b> <input type="checkbox"/> Responds to voice & noise (parent report) <input type="checkbox"/> Responds to noisemaker (optional) <input type="checkbox"/> Parental observation/concerns <b>Vision</b> <input type="checkbox"/> Ability to fix and follow, alternate occlusion, corneal light, red reflex <input type="checkbox"/> Parental observation/concerns <b>Lead Poisoning</b> Test date _____ <input type="checkbox"/> Lead level _____ mcg/dl (required for Medicaid) <input type="checkbox"/> Hct or Hgb _____ (required for Medicaid if not done at 9-month visit) If Risk: <input type="checkbox"/> IPPD _____ (result)
<b>Immunizations</b> <input type="checkbox"/> Immunizations Reviewed, Given, & Charted – if not given, document rationale <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB <input type="checkbox"/> Hib <input type="checkbox"/> PCV <input type="checkbox"/> MMR <input type="checkbox"/> Varicella or Chicken Pox Date: _____ <input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours WIC <input type="checkbox"/> Y <input type="checkbox"/> N ISS <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Developmental Questions and Observations on Page 2</b>
<b>Next Well Check: 15-18 months of age</b>
Provider Signature: _____

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N				
<b>Review of Symptoms</b>		<b>Physical Exam</b>		<b>Systems</b>
<b>N</b>	<b>A</b>	<b>N</b>	<b>A</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N Plan <input type="checkbox"/> History/Problem List/Meds Updated <input type="checkbox"/> Referrals <input type="checkbox"/> WIC <input type="checkbox"/> Early On <input type="checkbox"/> Transportation <input type="checkbox"/> Children Special Health Care Needs <input type="checkbox"/> Priority Health Case Mgmt 800 998-1037 <input type="checkbox"/> Other _____				

<b>Anticipatory Guidance / Health Education</b> (✓ if discussed)
<b>Healthy and Safe Habits</b> <b>Injury and Illness Prevention</b> <input type="checkbox"/> Keep home and car smoke-free <input type="checkbox"/> Keep Poison Control number handy <input type="checkbox"/> Appropriate car seat placed in back seat <input type="checkbox"/> Pool/tub/water safety <input type="checkbox"/> Don't leave heavy objects, hot liquids on tablecloths <input type="checkbox"/> Use stair gates, safety locks, window guards <input type="checkbox"/> Childproof home (dangling cords, poisons, medicines, outlets, guns, smoke detectors) <input type="checkbox"/> Watch near pets, mowers, driveways, streets <input type="checkbox"/> Limit time in sun, use hat/sunscreen <input type="checkbox"/> Check home for lead poisoning hazards <input type="checkbox"/> Avoid or limit TV viewing
<b>Nutrition</b> <input type="checkbox"/> Discuss weaning, use whole milk <input type="checkbox"/> Toddler should drink from cup <input type="checkbox"/> Avoid choke foods, limit sugar <input type="checkbox"/> 3 nutritious meals, 2-3 healthy snacks daily <input type="checkbox"/> Let child experiment with food, don't force eating, may have drop in appetite
<b>Oral Health</b> <input type="checkbox"/> Don't put toddler to bed with bottle <input type="checkbox"/> Discuss fluoride <input type="checkbox"/> Brush toddler's teeth with a soft toothbrush and water <input type="checkbox"/> Schedule first dental exam
<b>Social Competence</b> <input type="checkbox"/> Set simple limits (e.g., use distraction) <input type="checkbox"/> Delay toilet training <input type="checkbox"/> Interactive talking, singing, and reading <input type="checkbox"/> Expect curiosity about genitals <input type="checkbox"/> Daily/bedtime routine (put to bed awake) <input type="checkbox"/> Encourage safe exploration <input type="checkbox"/> Praise good behavior <input type="checkbox"/> Discourage hitting, biting, aggressive behavior
<b>Family Support and Relationships</b> <input type="checkbox"/> Special relationships with parents/caregivers <input type="checkbox"/> Encourage trusting relationships <input type="checkbox"/> Young siblings should not supervise toddler <input type="checkbox"/> Family planning <input type="checkbox"/> Limit caregivers and choose them carefully <input type="checkbox"/> Substance abuse, domestic violence, depression <input type="checkbox"/> Hold and cuddle child
<b>Community Interaction</b> <input type="checkbox"/> Discuss early intervention programs needed

Date	Patient Name	DOB
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**Developmental Questions and Observations**

Ask the parent to respond to the following statements about the toddler:

Yes      No

    Please tell me any concerns about the way your toddler is behaving or developing:

\_\_\_\_\_

- My toddler likes to be with me.
- My toddler is interested in people, places, and things.
- My toddler shows different feelings.
- My toddler drinks from a cup.
- My toddler eats a variety of foods.
- My toddler can make sounds.
- My toddler pulls self to standing position.

Ask the parent to respond to the following statements:

Yes      No

- I am sad more often than I am happy.
- I have people who help me when I get frustrated with my toddler.
- I am enjoying my time with my toddler.
- I have time for myself, partner, and friends.
- I feel safe with my partner.

Provider to follow up as necessary.

**Developmental Milestones**

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Toddler Development			Parent Development		
Stands alone 2 seconds or more	Yes	No	Appropriately disciplines toddler	Yes	No
Walks with help	Yes	No	Positively talks, listens, and responds to toddler	Yes	No
Says "Dada or Mama" specifically	Yes	No	Parent is loving toward toddler	Yes	No
Responds to No	Yes	No	Uses words to tell toddler what is coming next	Yes	No
Precise pincer grasp	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. <i>(Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents)</i>		
Indicates wants by pointing or gestures					
Is able to transition from one activity to another throughout the day					
Appears to have a secure, attached relationship with parent					

Additional notes from pages 1 and 2:

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**Family History Update**

Since your last visit, have there been any changes in your family history, include:

- Deaths: who \_\_\_\_\_ what age \_\_\_\_\_
- New medical diagnosis: who \_\_\_\_\_ what age \_\_\_\_\_
- Anything else in your family history you have concerns or questions with: (Refer to Family History form)

**Staff Signature:** \_\_\_\_\_ **Provider Signature:** \_\_\_\_\_

## Patient Education:

### Your Baby's Health at 12 months

#### Milestones: Ways your child is developing between 12 and 18 months

- Speaks more and more words: 3-10 words by 15 months; 15-20 words by 18 months
- Stacks two or three blocks
- Walks well, climbs steps with help, follows simple directions
- Knows names of some body parts (such as eyes, ears, and nose) and can point to them
- Is curious and likes to explore people, places, and things
- Plays beside other children, touches, hugs, and kisses
- Protests and says, "NO!"

#### Safety Tips

- Your child should ride in a rear-facing child safety seat in the back seat of the vehicle as long as possible. He/she should be at least 12 months old AND weigh at least 20 pounds before he/she is placed in a forward-facing toddler car seat.
- As your child learns to walk and climb, make sure your house is safe to explore. Keep the floor clean, lock poisons up, put things that break on a high shelf, and keep gates closed on stairs.
- Your child can choke on small objects. Keep small, hard, round objects (coins, small blocks) out of reach. Avoid giving round pieces of food, such as hot dog slices, grapes, or nuts to eat. Learn how to do the Heimlich maneuver.

#### Health Tips

- Make sure your child gets his/her immunizations on time to protect him/her from many serious diseases. If your child has missed any "shots," make an appointment to catch up.
- Your child should be eating different kinds of healthy foods. Eating small pieces of soft table food can give your child the nutrition he/she needs.
- Let your child drink from a cup.
- Brush your child's teeth at least once a day. Start to use a tiny pea-sized piece of toothpaste with fluoride. Take your child for his/her first dental checkup.
- Call your child's doctor or nurse before your next visit if you have any questions or concerns about your toddler's health, growth, or development.

#### Parenting Tips

- Play, read, and talk with your child every day. Repeat songs and nursery rhymes that he/she likes.
- Name child's feelings out loud – happy, sad, or mad. Use words to tell child what is coming next. Your child can understand more words than he/she can say. Give child simple choices. For example, "squash or peas?"
- Calmly set limits to keep child safe by giving your child something different to do. Praise your child when he/she does things that you like.
- When you are a parent you will be happy, mad, sad, frustrated, angry, and afraid, at times. This is normal. If you feel very mad or frustrated:
  - o Make sure your child is in a safe place (like a crib) and walk away.
  - o Call a good friend to talk about what you are feeling.
  - o Call the Parent Helpline at 800 942-4357 (in Michigan). It's free! They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

## For Help or More Information

### Priority Health

Customer Service 616 942-1221 or 800 446-5674  
 Medicaid 888 975-8102  
 Behavioral Health 616 464-8500 or 800 673-8043  
[priorityhealth.com](http://priorityhealth.com)

### Depression

Surrounding pregnancy and childbirth  
[www.depressionafterdelivery.com/Home.asp](http://www.depressionafterdelivery.com/Home.asp)

### Domestic Violence

National Domestic Violence Hotline  
 800 799-SAFE (7233)

### Health and Nutrition Program

Women, Infant, and Children (WIC) Program  
 800 262-4784

### The National Women's Health Information Center Breastfeeding Helpline

800 994-WOMAN (9662)  
[www.4woman.gov/breastfeeding](http://www.4woman.gov/breastfeeding)

LA LECHE League 847 519-7730  
[www.lalecheleague.org](http://www.lalecheleague.org)

### Special Health Care Needs

Children Special Health Care Services  
 MDCH Family 800 359-3722

### Childhood Development

Early On Michigan 800 327-5966  
 Michigan Head Start Association 517 374-6472

### Parenting Skills or Support

Parents Hotline 800 942-4357  
 Family Support Network of Michigan 800 359-3722

### Childcare

Child Care Licensing Agency, Michigan Department  
 of Consumer & Industry Services  
 517 373-8300

### Childhood Immunizations

National Immunization Program Hotlines  
 800 232-2522 (English) or 800 232-0233 (Spanish)

### Lead Screening

Michigan Department of Community Health Hotline  
 800 648-6942

### Prevention of Unintentional Childhood Injuries

National Safe Kids Campaign 202 662-0600  
[www.safekids.org](http://www.safekids.org)

### Car Seat Safety

Auto Safety Hotline 888 327-4236

### Poison Prevention

Call the Poison Control Center  
 800 222-1222