

Today's Date: _____

Patient

Name:

FMP and Sponsor

SSN last four:

Contact Number:

Date of Birth:

12 MONTH WELL CHECK

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)	Medications (PLEASE INCLUDE DOSAGE)
		Allergies Asthma Other:	<u>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</u>

Please list any known allergies your child has (drug, food, latex) _____ No Allergies

Circle if anyone in the family has had: Genetic or Metabolic Disease Kidney Disease Deafness before age 5

Birth Defects Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Did you child receive the Hepatitis B vaccine at birth? Yes No

Who does the child live with? _____

Does your child attend daycare? Yes No

Does anyone in the family smoke or is your child exposed to secondhand smoke? Yes No

Do you & and your child feel safe at home? Yes No

Breastfeeding? Yes No How often _____ Minutes per breast _____ Concerns _____

Formula feeding? Yes No Brand _____ Ounces per feed _____ Ounces per day _____

Drinks whole milk? Yes No Ounces per day _____ Drinks Juice Yes No Ounces per day _____

Good variety of table foods? Yes No

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

Check all the following that apply to your child:

Social/ Cognitive Communicative/ Physical Development	
<input type="checkbox"/> Uses mama or dada for specific parent	<input type="checkbox"/> Walks holding onto furniture
<input type="checkbox"/> Takes first independent steps or stands	<input type="checkbox"/> Cries when caregiver leaves
<input type="checkbox"/> Uses a gesture(waves bye or shakes head for no)	<input type="checkbox"/> Points to objects
<input type="checkbox"/> Bangs objects together	

Preferred Language: English Other: _____

What is your preferred method of learning: Verbal Written Visual Other: _____


Are there any cultural or religious considerations that may affect your child's healthcare? Yes No _____

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

Today's Date: _____

HR		LT		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____  USE FLACC SCALE FOR NON-VERBAL CHILDREN
		Naked WT		
		HC		
				Immunizations UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Technician Signature: _____

*Other VS per Provider request

HPI:

N E	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)

PLAN:

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:

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