atient [ame:		FMP and Sponsor SSN last four:	Contact Number: Date of Birth:
Oo you have any specific	12 M	ONTH WELL	
(Please complete inform	ation 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:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):
Please list any known allo Circle if anyone in the fa	ergies your child has (drug, foo mily has had: Genetic or Me		□ No Allergies  ey Disease Deafness before age 5
Birth Defects Early Dea	ath or Sudden Unexplai	ined Death of Infant or Child	d (to include SIDS)
•	Hepatitis B vaccine at birth?		
Vho does the child live w	vith?		<u> </u>
oes your child attend da	aycare? 🗆 Yes 🗆 No		
· ·	· ·	ed to secondhand smoke?	□ Yes □ No
oes anyone in the family	aycare? □ Yes □ No y smoke or is your child expos   feel safe at home? □ Yes □ No		□ Yes □ No
Ooes anyone in the family oo you & and your child	smoke or is your child exposed feel safe at home? ☐ Yes ☐ No	o	
ooes anyone in the family oo you & and your child creastfeeding?	y smoke or is your child expose feel safe at home? ☐ Yes ☐ No ☐ No ☐ How oftenMin	o utes per breast	_Concerns
oes anyone in the family o you & and your child reastfeeding?   Yes ormula feeding?   Yes	y smoke or is your child expose l feel safe at home? □ Yes □ No l No How oftenMin s □ No BrandOun	o autes per breastOun	Concerns ces per day
oes anyone in the family o you & and your child reastfeeding?   Ormula feeding?   Yes rinks whole milk?   Yes	y smoke or is your child exposed feel safe at home? ☐ Yes ☐ No ☐ No How oftenMines ☐ No BrandOunces ☐ No Ounces per day	o autes per breastOun	Concerns ces per day
oes anyone in the family o you & and your child creastfeeding?  Greatfeeding?  Yes ormula feeding?  Yes rinks whole milk?  Yeood variety of table food	y smoke or is your child exposed feel safe at home? ☐ Yes ☐ No ☐ No How oftenMines ☐ No BrandOunces ☐ No Ounces per day	outes per breastoues per feedOun_ Drinks Juice  Yes  No	Concerns ces per day Ounces per day
ooes anyone in the family oo you & and your child reastfeeding?  Formula feeding?  Formula feeding feedi	y smoke or is your child expose feel safe at home?   No How oftenMin   No BrandOun   S  No Ounces per day   ds?  Yes  No	outes per breastoues per feedOun_ Drinks Juice  Yes  No	Concerns ces per day Ounces per day
oes anyone in the family o you & and your child reastfeeding?   Yes ormula feeding?   Yes rinks whole milk?   Yed ood variety of table food	y smoke or is your child expose feel safe at home?   No How oftenMin   No BrandOun   S  No Ounces per day   ds?  Yes  No	outes per breastoues per feedOun_ Drinks Juice  Yes  No	Concerns ces per day Ounces per day
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Does anyone in the family to you & and your child Breastfeeding?   Formula feeding?   For	y smoke or is your child expose feel safe at home?   No How often Mines No Brand Ounces per day ds?   Yes No No ns about: Bowel movements / Compared that apply to your child:	outes per breastoues per feedOun_ Drinks Juice  Yes  No	Concerns ces per day Ounces per day
Does anyone in the family Do you & and your child Breastfeeding?  Formula feeding?	y smoke or is your child expose feel safe at home?  Yes No How often Mines No Brand Ounces per day ds?  Yes No No Brand Ounces per day ds?  Yes No No ns about: Bowel movements / Cognitive Cor	outes per breastoces per feedOun_Drinks Juice	Concerns ces per day Ounces per day is
Does anyone in the family Do you & and your child Breastfeeding?  Formula feeding?  Formula feeding?  Formula feeding?  Food variety of table food circle if you have concern Check all the following	y smoke or is your child expose feel safe at home?  Yes No No How often Min s No Brand Oun es No Ounces per day ds?  Yes No ns about: Bowel movements / Cog that apply to your child:  Social/ Cognitive Cor a for specific parent	outes per breastOun_ ces per feedOun_ Drinks Juice    Yes    No Constipation / Sleep problem mmunicative/ Physical D	Concerns ces per day Ounces per day as Development miture
Does anyone in the family Do you & and your child Breastfeeding?   Formula feeding?   Formula feeding fe	y smoke or is your child expose feel safe at home?  Yes No No How often Min s No Brand Oun es No Ounces per day ds?  Yes No ns about: Bowel movements / Cog that apply to your child:  Social/ Cognitive Cor a for specific parent	nutes per breastOun_ Loces per feedOun_ Drinks Juice    Yes    No Constipation / Sleep problem mmunicative/ Physical D Walks holding onto fur	Concerns ces per day Ounces per day as Development miture
Does anyone in the family Do you & and your child Breastfeeding?   Formula feeding?   Formula feeding?   Formula feeding?   Food variety of table food variety of table food variete if you have concern the conce	y smoke or is your child expose feel safe at home?  Yes No No How often Mines No Brand Ounces per day ds?  Yes No ns about: Bowel movements / Cog that apply to your child:  Social/ Cognitive Core for specific parent dent steps or stands yes bye or shakes head for no)	nutes per breast	Concerns ces per day Ounces per day as Development miture
Does anyone in the family Do you & and your child Breastfeeding?   Formula feeding?   Formula feeding?   Food variety of table food variety of table food variety of table food ircle if you have concern Check all the following   Uses mama or dada   Takes first independent   Uses a gesture(way)	y smoke or is your child expose feel safe at home?  Yes No No How often Mines No Brand Ounces per day ds?  Yes No ns about: Bowel movements / Cog that apply to your child:  Social/ Cognitive Core for specific parent dent steps or stands yes bye or shakes head for no)	nutes per breast	Concerns ces per day Ounces per day as Development miture
Does anyone in the family Do you & and your child Breastfeeding?  Greastfeeding?  Gromula feeding?  Yes Prinks whole milk?  Yes dood variety of table food variety of table food variet if you have concerns  Check all the following  Uses mama or dada  Takes first independent  Uses a gesture(wave Bangs objects together  Bangs objects together  Double Prince Pr	y smoke or is your child expose feel safe at home?  Yes No How often Mines No Brand Ounces per day ds?  Yes No Ounces per day shows about: Bowel movements / Cognitive Core for specific parent dent steps or stands res bye or shakes head for no) ther	nutes per breast	Concerns ces per day Ounces per day as Development miture
oes anyone in the family o you & and your child reastfeeding?  Freastfeeding?  Freastfeeding.	y smoke or is your child expose feel safe at home?  Yes No How often Mines No Brand Ounces per day day Yes No ns about: Bowel movements / Compared for specific parent dent steps or stands res bye or shakes head for no) ther	nutes per breast	Concerns ces per day Ounces per day is  Development  miture eaves
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Preferred Language:	y smoke or is your child expose feel safe at home?  Yes No How often Mines No Brand Ounces per day day Yes No ns about: Bowel movements / Compared for specific parent dent steps or stands res bye or shakes head for no) ther	utes per breastOun_ Drinks Juice	Concerns ces per day Ounces per day  S  Development  miture  eaves  er: althcare? □ Yes □ No

hoT	av's	Da	te:

HR	LT	Pain:   Yes  No Location of Pain
	Naked WT	No Hurt Hurts Hurts Hurts Hurts Hurts Hurts Worst USE FLACE SCALE FOR NON-VERBAL CHILDREN
	нс	Immunizations UTD per AFCITA: ☐ Yes ☐ No Technician Signature:

HPI:

N E	<b>Examination:</b>	Normal	Abnormal
	General:	□ Active/Alert/WN/WD/NAD/ not dysmorphic	
	Head/Neck:	□ NCAT/Nontender/FROM	
	Eyes:	☐ RR X2, nl corneal reflex, EOMI, no strabismus	
	R ear:	☐ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
	L ear:	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
	Nose:	□ Patent, No congestion/discharge	□ Congested
	Oropharynx:	☐ Pink, moist, no lesions ☐ Teeth: Nl, no signs of caries	
	Lungs:	☐ CTAB, no retractions, nl WOB	
	CV:	□ RRR, no murmur, strong femoral pulses, cap refill < 2 sec	
	Abd:	☐ Soft, NT, no HSM, no mass, nl BS, no umbilical/inguinal hernia	
	Ext/Spine:	□ NL, FROM, nontender, no edema, no lumbosacral pits	
	Skin:	□ No rash, No bruises	
	Hips:	□ Full ROM, Symmetric leg folds	
	Neuro:	□ Normal tone/strength/symmetry	
	Genitalia:	□ Nl female/no adhesions □ Nl male, Testes down	
	Other findings:		

**LABS/X-RAYS:** □ H&H (12 months): □ Lead Screening (if applicable)

PLAN:

_	months, sooner if parental co zes understanding of treatment a		Anticipatory gui	dance hand	out provide	ad.
1 attent and/or parent verban.	zes understanding of treatment a	na pian 🗆	Anticipatory gui	uance manu	out provide	.u
<b>PREVENTION</b> : □ Nutrition	☐ Sippy Cups/No Bottle ☐ Der	ntal care	√Falls □ Car Se	at □ Child-p	roofing th	e house
□ Tobacco avoidance		RECORDS				
		MAINTAINED AT:				
		PATIENT'S NAME (Last, First, Middle Initial)				SEX
		RELATIONSHIP TO SPOR	NSOR	STATUS		RANK/GRADE
Signature:	Date:					
Stamp:		SPONSOR'S NAME			ORGANIZATION	
		DEPART./SERVICE	SSN/IDENTIFICATION N	TIFICATION NO.		DATE OF BIRTH

<sup>\*</sup>Other VS per Provider request