Name FMP/SSN last four: DOB:

Email Address : Contact Phone Number:

12 - 23 MONTH VISIT

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) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **Premie** **Overweight** **Chronic ear infections** **Other: (reflux)**	Example circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** ❑ Infant Multivitamin 1 ml per day

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify _____

Circle if anyone in the family has had:

Genetic or Metabolic Disease/Birth Defects / Kidney Disease / Deafness < 5 years old/
Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Please list any known **allergies** your child has (drug, food, latex) _____

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

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend daycare? ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

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

Preferred language: ❑ English ❑ Other: _____

Please See Reverse Side

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

STANDARD FORM 600 Overprint

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

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Diet History:

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

Bottle feeding? ❑ Yes ❑ No Brand? _____ Ounces per feed? _____ Ounces per day? _____

Drink whole milk? ❑ Yes ❑ No How many ounces per day? ____

Drink juice? ❑ Yes ❑ No How many ounces per day? _____

Good variety of table foods? ❑ Yes ❑ No

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

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Cough	Yes/No	Duration?_____
Headache	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Earache	Yes/No	Duration?_____	Abdominal pain	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Sore throat	Yes/No	Duration?_____	Other (describe)_____		

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child:

12 MONTHS	15 -18 MONTHS	24 MONTHS
❑ Says "Mama" and "Dada"	❑ Has 3-10 words	❑ Uses 50 words or more
❑ 3 words other than mama/dada	❑ Follows simple commands	❑ Says 2-3 word sentences
❑ Points at objects to show you	❑ Listens to you read a book to them	❑ Turns single pages in a book
❑ Imitates simple tasks	❑ Points to a body part	❑ Stacks 5 or more blocks
❑ Grabs small objects with finger and thumb	❑ Points at objects to ask for them	❑ Takes off their own clothes
	❑ Walks without help	❑ Runs well
❑ Waves Bye-Bye	❑ Walks well, stoops and climbs stairs	❑ Kicks a ball forward
❑ Stands well alone	❑ Stacks 2 blocks	❑ Walks up stairs
❑ Walks holding onto furniture	❑ Scribbles	
❑ Bangs things together	❑ Drinks from a cup / Feeds self	

Lead Screening:

Does your child have a sibling/playmate with lead poisoning?			❑ Yes ❑ No
Does your child live in/visit a house/daycare built:		Before 1978 with chipping/peeling paint?	❑ Yes ❑ No
Before 1950?	❑ Yes ❑ No	Before 1978 undergoing renovations?	❑ Yes ❑ No

PLEASE GIVE THIS FORM TO YOUR PROVIDER'S ASSISTANT