Iowa Child Health and Development Record

12 month Well Exam

Date_____ **Patient #**_____

Name_____ **Date of Birth**_____

Address_____

Lives with: ❑ 1 parent ❑ 2 parents ❑ Other caregiver

❑ Others (including siblings)_____

May release information to: (parent, guardian, other family -- list)_____

Parental concerns: _____

Changes in child's health since last visit:_____

GENERAL HEALTH:

Nutrition: ❑ Breast: ____times/day
❑ Bottle____oz/day

YES	NO	
❑	❑	Drink from a cup?
❑	❑	Table/finger foods?

Solids: ❑ Cereals ❑ Fruits ❑ Vegetables ❑ Meats

❑ Juice ____oz/day

Daily oral health care? ❑ **Yes** ❑ **No** ❑ No teeth

❑ Dental visit?

Elimination: ❑ Stooling: soft, easy to pass BMs_____

Sleep:____hours through the night

YES	NO	
❑	❑	Problems? Night feedings?_____
❑	❑	Bottle to bed?

DEVELOPMENT: Screen or refer if concerns or "No" response on milestones in **bold type**

YES	NO	
❑	❑	**Strong attachment to primary caregiver**
❑	❑	**Points or uses other gestures such as waving***
❑	❑	**Babbles, says "ma-ma" "da-da" specifically (13 months)***
❑	❑	**Picks up Cheerio with thumb and finger**
❑	❑	**Understands "no" or their name***
❑	❑	**Pulls to standing position**
❑	❑	**Gets to sitting position** (***autism risk**)
❑	❑	May walk without support

Family concerns about speech, learning, motor skills, behavior?

_____

MEDICAL HISTORY:

Allergies:_____ Meds:_____

Major medical illnesses/special health care needs:_____

_____

Hospitalizations/Surgeries:_____

_____

FAMILY HISTORY: ❑ Reviewed and updated

SOCIAL HISTORY:

Childcare: _____

FAMILY RISK FACTORS:

Changes in family since last visit:_____

_____

Stress: How much stress are you and your family under now?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

What kind of stress? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ Violence/Abuse ❑ Lack of help ❑ Financial
❑ Health Insurance ❑ Child care ❑ Other _____

How stressful is caring for your child?
❑ None ❑ Slight ❑ Moderate ❑ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless? ❑ No ❑ Sometimes ❑ **Often**

In the past month have you/partner felt little interest or pleasure in doing things? ❑ No ❑ Sometimes ❑ **Often**

ANTICIPATORY GUIDANCE: ❑ Check if discussed

FAMILY WELL-BEING:

- ❑ Time for self and partner. Family–work balance. Support
- ❑ "Tell me about your family traditions"
- ❑ Limit screen time for older siblings <2h, monitor content
- ❑ Family meals, bedtime routine - include reading

BEHAVIOR:

- ❑ Establish daily routine with meals, snacks, naps, bedtime
- ❑ Continue to read, sing, and play with child (No TV,videos)
- ❑ Consistent behavior management: distraction, positive reinforcement, "time outs"
- ❑ Ignore temper tantrums

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- ❑ Transition to soft table food, wean from bottle.
- ❑ Eating with family at table (secure seating). 3 meals and 2 snacks - no grazing or carrying cup around
- ❑ Offer healthy food, child decides amount. Encourage feeding self
- ❑ Choose a dentist and first visit by 12 months or 1st tooth
- ❑ Brush teeth 2 times a day with smear of fluoride toothpaste. If still has bottle, offer only water

SAFETY:

- ❑ As mobility increases, safety concern also increases.
- ❑ Review car restraints – continue rear-facing as long as possible.
- ❑ Child Safety Seat Inspection Locator: 866-732-8243, www.seatcheck.org
- ❑ Lead exposure, water & gun safety.
- ❑ If smoking in home: discuss quitting, limiting exposure

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ Weight_____(_____%)

Length_____(_____%) Wt/Length_____% Head circumference_____(_____%)

N Abn *Comment on abnormal findings*

❑ ❑ General appearance_____

❑ ❑ Behavior/interaction with family_____

❑ ❑ Skin_____

❑ ❑ Head/scalp_____

❑ ❑ Ears_____

❑ ❑ Eyes_____

❑ ❑ Nose_____

❑ ❑ Mouth/Throat _____

❑ ❑ Teeth_____

❑ ❑ Neck _____

❑ ❑ Back/Chest_____

❑ ❑ Lungs_____

❑ ❑ Heart_____

❑ ❑ Abdomen_____

❑ ❑ Genitalia _____

❑ ❑ Musculoskeletal_____

❑ ❑ Neurologic _____

Results reviewed: (outside info, lab, etc.)_____

Impression:_____

_____

PLAN OF CARE (see Anticipatory Guidance)

❑ **Fluoride varnish given** (if high risk, such as all Title 19 patients)

Immunizations: ❑ Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: ❑ No ❑ Yes

See current guidelines www. immunize.org/aap

LAB: ❑ Lead ❑ Hb or Hct ❑ TB if high risk ❑ other if indicated_____

Developmental Follow-up ❑ No delays ❑ Follow-up in office ❑ Referral

Referral: (if indicated)_____

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229

For referral of children ***birth to age 3*** with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts:_____

Return appointment:_____

Signature _____ Date _____