

7-12 Months

Department of State Health Services Child Health Record Preventive Health Visit

Family Profile and Health

No change in household since last visit
Child lives with:
 Mother Father Stepparent Grandparent
 Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: P F

Type of Developmental Screen:

Standardized Parent Questionnaire: _____

Standardized Observational Screen: _____

Other: _____

Further assessment needed: Y N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems
or parent concerns: Y N

Explain:

Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Physical Examination

Temp _____ Pulse _____ Resp _____

FOC _____ Height _____ Weight _____

(%) _____ (%) _____ (%) _____

N A N E

Appearance
 Head/fontanelles
 Skin/nodes
 Eyes
 Ears
 Nose
 Mouth/throat
 Teeth
 Neck
 Chest/breasts

N A N E

Heart/pulses
 Lungs
 Abdomen
 Genitalia/anus
 Spine/hips
 Extremities

Neurologic:

Muscle tone
 DTRs

Additional documentation:

Client Information

Name: _____

DOB: _____ / _____ / _____ Age: _____ Sex: _____

SSN/Record No.: _____

Race/Ethnicity: _____

Informant/Relationship: _____

Medical Home: _____

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* Y N
**If answered yes, further assessment needed.*

Breast-fed: Number of feedings in last 24 hours: _____

Length of feedings: _____ **WIC:** Y N

Formula-fed: Type: _____

Iron fortified: Y N

Ounces consumed in 24 hours: _____ Fluoride: Y N

Solid foods introduced at age:

Sensory

Vision Screen: Normal Abnormal

Hearing Screen: Normal Abnormal

Screen used: Hearing Checklist for Parents

Health Education

Injury Prevention

Car safety restraints
 Falls (stairs, gates)
 Choking management
 Water safety/temp
 Poisoning
 Child proofing
 Passive smoking

Health Promotion

Immunizations
 Teething
 Cleaning teeth
 When to call doctor
 Well-child care
 Dental appointment
 Family planning

Behavior

Parent/infant interaction, expectations
 Speech development
 Sleep
 Separation protest
 Daycare

Nutrition

Breastfeeding support
 Introduction of solids
 No bottle in bed
 Off bottle by 1 year

Assessment

Plan

TB: Y N **Dental referral made:** Y N

WIC: Referred Refused N/A

Immunizations: Up to date To be given today Deferred

Explain:

Lab:

Newborn Screening: Up to date To be done today

Hct/Hgb Lead _____

Hep C (if 12 months old or older and born to HCV infected woman) _____

Next appointment:

Date: _____ Signature/Title: _____ Signature/Title: _____

