



WELL CHILD VISIT

1 Year

Name _____ Age in Months _____ Date of Visit _____

Concerns/Discussion

- Speech
- Sleep
- Family concerns
- Illness/Accidents
- Other concerns
- Observe parent/Child interaction

Nutrition

Meals

- Frequency _____ times/day
- Food Variety _____

Bottle/Breast

- Frequency _____ times/day

Guidance

- 3 meals and 2-3 snacks per day
- Offer variety of soft table foods
- Family meals
- Make mealtimes pleasant
- "Up and down" appetite normal
- Discuss weaning from bottle/breast
- Switch to whole pasteurized milk
- Choking hazards

Developmental/Behavioral

- Pulls to stand and "cruises"
- Social games - "peek-a-boo"
- Pincer grasp
- 2-3 Words
- Drinks from cup
- Waves "bye-bye"
- Feeds self with hands

- Temperament/Parent description

Physical Exam

- General
- Wt _____ % _____
- Ht _____ % _____
- HC _____ % _____
- Monitor growth chart
- Temp _____
- Skin
- Nodes
- Head
- Eyes
- Ears
- Nose
- Oropharynx
- Neck
- Chest/Breast
- Lungs
- Cardiovascular
- Abdomen
- Genitalia
- Hips/Extremities
- Neuro
- Evidence of Neglect/Abuse

Screening/Immunizations

Screening

- Hearing (exam & history)
- Vision (exam & history)
- Lead—Screen high risk (educate everyone)
- Anemia—Hgb/Hct (if not done at 9 months)
- Tuberculosis—PPD if high risk
- Dental
 - Discuss fluoride
 - Exam and refer if abnormal
 - Educate on care

Immunizations

- Per ACIP schedule (Record below)

Anticipatory Guidance

- Injury/Accident prevention (car, falls, burns, sunscreen, drowning)
- Importance of praising children (discipline discussion)
- Limit number of rules
- Encourage safe exploration
- Read to child
- Family time with child
- Appropriate babysitters

Immunizations given:

Record all abnormal findings below.

Assessment and Plan: _____

PHN Referral (if indicated) _____ WIC Referral (if indicated) _____

Physician Signature: _____