

**SOUTHLAKE PEDIATRICS
HEALTH SUPERVISION VISIT 12 MONTHS**

Name: _____ DOB: _____

Date of Visit _____ Age _____

Parental Language Barrier: N Y _____

PARENTAL CONCERNS/ONGOING & INTERIM PROBLEMS

No Concerns

PAST MEDICAL HISTORY

Allergies _____ Immunization Reactions _____

Other _____

PRESENT HISTORY

Medications: _____

Diet: _____

Formula/Breast Milk _____

Cup/Weaning _____

Solids/Food groups _____

Self-feeding _____

Bowel movements _____

Sleep/Naps _____

Dental _____

DEVELOPMENT

Cruises/Stands alone/Walks _____

Speech (2-4 words) _____

Patty Cake/Waves bye-bye _____

SOCIAL/FAMILY

Parents/Caregiver Smoker Yes No _____

Behavior/Discipline _____

Stranger Anxiety _____

Other _____

Information completed by: _____

Relationship to child: _____

PHYSICAL EXAMINATION

Length _____ % Weight _____ %

HC _____ % Temp _____ Pulse _____ RR _____

N AB COMMENTS

Gen. Appearance _____

Skin _____

Head/Fontanel _____

Eyes/RR/Strabismus _____

Ears/Nose/Oropharynx _____

Neck/Nodes _____

Chest/Lungs _____

Cardiovascular/Pulses _____

Abdomen _____

Genitalia _____

Musculoskeletal/Hips _____

Neuro/Reflexes _____

Hearing _____

Vision _____

ANTICIPATORY GUIDANCE

Diet

Meal Structure

Whole Milk

Healthy Snacks

Limit juice

Basic four/balance

Choking

Drowning/water safety

Climbing

Medical Education

Review immunizations

Acetaminophen dose

No smoking

Poison Control #

Telephone

Dental Education

Discontinue bottle

Clean teeth

Development

Language stim/reading

TV: watch with child

Separation/transitional object

Time out/Time in

Injury Prevention

Car Seat

LABS:

Hgb/Hct _____ Lead (Risk Factors Yes No)

Tb Skin Test _____ (Risk Factors Yes No)

IMMUNIZATIONS: Varicella MMR Hep A

Other _____

Vaccine Information Sheet given & discussed

Vaccine concerns? No Yes: Resolved Deferred Refused
Comments _____

If vaccines not given, form signed? No Yes

ASSESSMENT/RECOMMENDATIONS:

Healthy infant _____

 Return for 15 month checkup

_____, M.D.

SICK VISIT – Mod 25

CC:

HPI:

MDM:

>50% of _____ min visit spent counseling