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 Screening: _____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/Interim History

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__________ Length ___________Weight___________

(%)___________ (%) ______________(%)______________

N	A	NE		N	A	NE	
___	___	___	Appearance	___	___	___	Heart/pulses
___	___	___	Head/fontanels	___	___	___	Lungs
___	___	___	Skin/nodes	___	___	___	Abdomen
___	___	___	Eyes	___	___	___	Genitalia/anus
___	___	___	Ears	___	___	___	Spine/hips
___	___	___	Nose	___	___	___	Extremities
___	___	___	Mouth/throat				**Neurologic:**
___	___	___	Teeth	___	___	___	Muscle tone
___	___	___	Neck	___	___	___	DTRs
___	___	___	Chest/breasts				

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

Behavior

___Parent/infant interaction, expectations
___Speech development
___Sleep
___Separation protest
___Daycare

Health Promotion

___Immunizations
___Teething
___Cleaning teeth
___When to call doctor
___Well-child care
___Dental appointment
___Family planning

Nutrition

___Breastfeeding support
___Introduction of solids
___No bottle in bed
___Off bottle by 1 year

Assessment

Plan

TB Risk Screening Tool (12 months): _____

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 ___ Blood lead test (at 12 months): _____

Lead questionnaire (at 9 months): _____

Next appointment:

Date: ______________ Signature/Title: ______________________ Signature/Title ______________________

7–12 Months

If used for documentation:____________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream
Neuromuscular: Coordination
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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