12 Month Well Exam

meridianhealth
A WellCare Company

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:______

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 Inspector Locator: 866-732-8243, www.seatcheck.org
- ☐ Lead exposure, water and gun safety
- ☐ If smoking in home, discuss quitting, limiting exposure

REFERRALS

☐ WIC ☐ FMIC ☐ Other______

DEVELOPMENTAL FOLLOW-UP

☐ No delays ☐ Follow-up in office
☐ Referral______ ☐ Other______

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care: ______

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?
☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other______
How stressful is caring for your child?
☐ 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**

GENERAL HEALTH

☐ 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
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" or "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?

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MEDICAL HISTORY

Name_______________ Date of Birth_______________

Allergies_______________ Medications_______________

Major medical illnesses/special healthcare needs _______________

Hospitalizations/Surgeries _______________

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:______R:______T:______Weight:______(______%)

Length ______ (______%) Wt/Length______% Head circumference______(______%)

Review of Systems

N	Abn	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	
☐	☐	☐	☐	Neurological	

Results reviewed (outside info, lab, etc.)_______________

Impression_______________

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused_______________

Lab ☐ Lead ☐ Hb or Hct ☐ other if indicated _______________

☐ **Fluoride varnish given** (CPT Code D1206)

Medical referral (if indicated)_______________

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Handouts: ☐ MHP Age 12 month handout
☐ Other_______________

Return appointment_______________

Signature_______________ Date_______________

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