

12 MONTH WELL CHECK HEALTH QUESTIONNAIRE



This information is confidential.

Your answers help your physician or nurse practitioner choose the best topics to discuss with you at this visit. Skip any questions you don't understand or do not apply.

PHONE: _____

What does your child like to do? Do you have any questions or concerns?

- | | |
|---|--|
| 1. Do you feed your child Vitamin D whole (full fat) cow's milk? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you avoid feeding your child foods that he or she may choke on (nuts, hard or jelly candies, popcorn, raw vegetables)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Do you limit juice to less than 6 ounces per day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Does your child drink any water with fluoride or take fluoride drops every day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. Have you started weaning your child from the bottle? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. Do you watch your child at all times around water (like a pool, hot tub, or bucket)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7a. Do you have a swimming pool or hot tub in your backyard? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7b. Is there a childproof fence around it? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 8. Do you know what to do if your child is choking? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 9. Does your child always ride in a car seat in the back seat? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 10. Does your child spend time in a home where anyone smokes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Since your last well check, have there been any MAJOR illnesses, hospitalizations, surgeries, changes, or stresses for your family or child? If yes, please list: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Please list any medications your child is taking: | |
| 13. Does your child have any allergies to medications? If yes, please list: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Do you brush your child's teeth with water every day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 15. Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Does your child receive Medi-Cal or other government assistance (WIC)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Has anyone who lives in your house or a baby sitter ever had a positive TB (Tuberculosis) skin test or active TB? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Were you (or any household members) born outside of the United States, or have you recently traveled to a developing country (Central or South America, Asia, or Africa)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Has your child lived outside the U.S. for more than one month? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Do you play and read with your child every day? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 21. Does your child play pat-a-cake? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 22. Does your child walk with support? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 23. Does your child pick up small objects with thumb and pointer finger? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 24. Does your child say words? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 25a. Is your child in day care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25b. Who else takes care of your child? | |
| 26. Has your child ever had a reaction to a vaccine (such as a high fever)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

CLINIC COUNSELING

- Questionnaire reviewed
- Pertinent topics discussed and advice given

Sign: _____

Parent signature: _____ Date: _____

12 MONTH WELL CHECK



KAISER PERMANENTE®

AGE: _____ MONTHS OLD

WEIGHT: _____ LBS / OZ / KG _____ %

HEIGHT: _____ IN / CM _____ %

HEAD CIRC: _____ IN / CM _____ %

Date _____ MA / LVN / RN SIGNATURE _____

ADDITIONAL HISTORY

See Health questionnaire

X OR ✓ = YES, DISCUSSED, ORDERED BLANK = No, NOT DISCUSSED OR ORDERED

ACCOMPANIED BY: Mother Father Relative Other:

PHYSICAL EXAM

NL (NL = Normal, AB = abnormal, Blank = not examined) **AB**

- | | |
|--|--------------------------|
| <input type="checkbox"/> GENERAL: (alert, responsive) | <input type="checkbox"/> |
| <input type="checkbox"/> SKIN: (clear, w/o lesions) | <input type="checkbox"/> |
| <input type="checkbox"/> HEAD: (normocephalic, atraumatic) | <input type="checkbox"/> |
| <input type="checkbox"/> EYES: (PERRL, EOMI, bilateral red reflex) | <input type="checkbox"/> |
| <input type="checkbox"/> E.N.T.: (TM's normal, nares clear, pharynx benign) | <input type="checkbox"/> |
| <input type="checkbox"/> LYMPH: (no enlarged lymph nodes) | <input type="checkbox"/> |
| <input type="checkbox"/> NECK: (neck supple, w/o adenopathy, no masses) | <input type="checkbox"/> |
| <input type="checkbox"/> CHEST: (chest clear) | <input type="checkbox"/> |
| <input type="checkbox"/> C.V.: (heart regular rhythm, no murmur, femorals full) | <input type="checkbox"/> |
| <input type="checkbox"/> ABDOMEN: (abdomen soft, no HSM, no masses) | <input type="checkbox"/> |
| <input type="checkbox"/> G.U.: (normal female/male, testes descended) | <input type="checkbox"/> |
| <input type="checkbox"/> BACK: (back OK) | <input type="checkbox"/> |
| <input type="checkbox"/> EXTREMITIES/HIPS: (feet, hips OK) | <input type="checkbox"/> |
| <input type="checkbox"/> NEURO: (age appropriate, nonfocal) | <input type="checkbox"/> |

Abnormal findings/comments:

ASSESSMENT

#1 _____ MONTH-OLD CHILD WELL

#2

#3

TREATMENT PLAN

- | | | |
|----------------------|---|--|
| #1 SAFETY | <input type="checkbox"/> See questionnaire | |
| NUTRITION | <input type="checkbox"/> See questionnaire | <input type="checkbox"/> Fluoride 0.25mg |
| PARENTING | <input type="checkbox"/> See questionnaire | |
| IMMUNIZATIONS | <input type="checkbox"/> Hep B <input type="checkbox"/> HIB | <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> ConPneumo <input type="checkbox"/> MMR |
| | <input type="checkbox"/> VZ <input type="checkbox"/> PPD | <input type="checkbox"/> VIS per protocol |
| LABS: | <input type="checkbox"/> CBC <input type="checkbox"/> Lead | |

#2

#3

R.T.C. for 14-15 Month Well Check or P.R.N.

Signature of MD/DO/NP: