12 Month Well Exam

Name
Room
Notes

Weight	T	Hgb/Hct
Length	HR	
OFC	RR	
	O2	

Nutrition

What type of milk does your child drink?	Whole	2%	1%	Breast	Formula
How much milk does your child drink?	12-16oz	<12oz	>16oz		
What foods does your child eat?	Veggies	Fruit	Protein		

Dental

Do you brush your child's teeth?	Yes	No
Has your child seen a dentist yet?	Yes	No

Sleep

Does your child sleep through the night?	Yes	No
How many naps does your child take per day?	2 or more	<2

Development

Do you feel that your child sees well?	Yes	No
Do you feel that your child hears well?	Yes	No
Does your child say at least 3 words (mama, dada, baba)?	Yes	No
Can your child feed himself/herself?	Yes	No
Can your baby stand alone or take a step?	Yes	No
Does your baby point at things he/she wants?	Yes	No
Is your child shy with strangers?	Yes	No
Do you read to your child?	Yes	No

Safety

Have you babyproofed your home?	Yes	No
Do you have the number to Poison Control?	Yes	No
Do you use a rear-facing carseat for your child?	Yes	No
Any smokers at home?	No	Yes

Risk Assessment

Has your child traveled outside of the U.S. in the last 6 months?	No	Yes
Exposure to anyone with a positive TB skin test?	No	Yes
Does your child live in or visit a home built before 1978?	No	Yes
Does your child live in or visit a home with chipping paint?	No	Yes

Followup D/W/M
Reason:

□EHR