

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Actual Age: \_\_\_\_\_

Language Spoken \_\_\_\_\_ Interpreter Name \_\_\_\_\_

Date: \_\_\_\_\_

**12 - 15 MONTHS**

**NURSING INTAKE**

Height:	Weight:	H.C.:	Temp.:	Pulse:	Resp.:
Allergies:			Growth Charts Completed: [ ]		
Abuse: Witness or Victim:			Notes:		
Alternate health care provider:			MA Signature		

**INTERVAL HISTORY**

Diet:	Has WIC: Yes / No	Physical activity:
Accidents:	Breastfeed or Bottle	Stools:
Illnesses:		Meds./Vits.:
		Exposure to tobacco smoke:
		TB Risk: Yes / No

**GROWTH-DEVELOPMENT:**

<input type="checkbox"/> Walks alone well	<input type="checkbox"/> Feeds self
<input type="checkbox"/> Takes lids off containers	<input type="checkbox"/> Plays pat-a-cake
<input type="checkbox"/> Holds cup to drink	<input type="checkbox"/> Stoops and recovers
<input type="checkbox"/> Dada, Mama specific	<input type="checkbox"/> Scribbles
<input type="checkbox"/> 3 word vocabulary	<input type="checkbox"/> 2 block tower

**PARENTAL CONCERNS:**

\_\_\_\_\_

\_\_\_\_\_

**PHYSICAL EXAMINATION**

General Appearance	<input type="checkbox"/> Well nourished and developed	Teeth	<input type="checkbox"/> Grossly normal
	<input type="checkbox"/> No abuse/neglect evident	Heart	<input type="checkbox"/> No murmurs, regular rhythm
Head	<input type="checkbox"/> Symmetrical, A.F. open _____ cm	Lungs	<input type="checkbox"/> Breath sounds normal bilaterally
Eyes	<input type="checkbox"/> Conjunctivae, sclerae, pupils normal	Abdomen	<input type="checkbox"/> Soft, no masses, liver & spleen normal
	<input type="checkbox"/> Red reflexes present	Genitalia: Male	<input type="checkbox"/> Normal appearance, circ./uncirc.
	<input type="checkbox"/> Appears to see <input type="checkbox"/> No strabismus	Female	<input type="checkbox"/> Testes in scrotum
Ears	<input type="checkbox"/> Canals clear, TMs normal	Hips	<input type="checkbox"/> No lesions, nl external appearances
	<input type="checkbox"/> Appears to hear	Femoral pulses	<input type="checkbox"/> Good abduction
Nose	<input type="checkbox"/> Passages patent	Extremities	<input type="checkbox"/> Present and equal
Mouth & pharynx	<input type="checkbox"/> Normal color, no lesions	Skin	<input type="checkbox"/> No deformities, full ROM
Neck	<input type="checkbox"/> Supple, no masses palpated	Neurologic	<input type="checkbox"/> Clear, no significant lesions
			<input type="checkbox"/> Alert, moves extremities well

**ASSESSMENT:**

\_\_\_\_\_

\_\_\_\_\_

**PLAN:**

\_\_\_\_\_

\_\_\_\_\_

**ORDERS:**

<input type="checkbox"/> Vaccine reactions, risks and follow-up explained / VIS sheet given.	<input type="checkbox"/> Hep A
<input type="checkbox"/> MMR	<input type="checkbox"/> Lead Blood Test (at 12 months)
<input type="checkbox"/> DTaP	<input type="checkbox"/> Influenza vaccine
<input type="checkbox"/> IPV	<input type="checkbox"/> Varicella
<input type="checkbox"/> Hib	<input type="checkbox"/> WIC Referral
<input type="checkbox"/> Hep B	<input type="checkbox"/> Immunization registry entry
<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> HCT (between 9 to 12 months)
	<input type="checkbox"/> Rx for fluoride .25/.50 mg QD, refill till age 2
	<input type="checkbox"/> PPD
	<input type="checkbox"/> Refer to dentist at 1 year

**ANTICIPATORY GUIDANCE: Circle if discussed**

Diet: Table food, milk, junk food, using cup/bottle, encourage solids, no bottles in bed.

Behavior: Feeding self, simple games      Education on Fluoride varnish treatment and dental referral starting at one year

Injury & Violence prevention: No hard objects or food the size of baby's pinky, toddler car seat, emergency care plan, smoke detector, drug and toxic chemical storage, poison center phone no., childproofing: safety gates, window guards, pool fence, hot liquids and surfaces, hot water temp., drowning, street safety, gun in home, home first aid kit, matches, cabinets and latches, lead poisoning prevention.

Guidance: Explain temper tantrum, family play, masturbation, not ready for toilet training, shoes, bottle, toothbrush, treatment of minor cuts & bruises, childcare plan, sun screen.

Refer to appropriate agency.

Return for Hep A#2 in 6 months.

Next appointment [ ] 3 months or \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_