Four Seasons Pediatrics

Well Visit Form for 9 Month, 12 Month & 15 Month Well Visit

Child's Name: ________________________ Birth Date: _________ Age: ______

Today's Date: _________

Feeding History:

- What kind of milk (breast or formula and type) does your child take? ___________________
- If Bottle-fed – ounces usually ingested in 24 hours: ________
- If Breast-fed: # feedings/24 hours: ________
- Is your child on solids? ________
- Does your child often have diarrhea? ________
- Any problems with feeding? ________
- Is your child on fluoride drops? ________

Behavior:

- Any problems with your child's sleeping? ________
- Does your child have any difficult behavior you would like to change?

____

Illnesses:

- If your child is on medicines, name them: ________________________________
- Has your child had any serious illnesses since the last check up? ________________

Development:

Please check the boxes to indicate if your 9 month old does the following:

[ ] Pokes his/her fingers at objects
[ ] Sits well by him/herself
[ ] Creeps on the floor
[ ] Babbles and imitates sounds
[ ] Waves bye-bye or plays pat-a-cake
[ ] Turns to your voice when you are talking

Please check the boxes to indicate if your 12 month old does the following:

[ ] Puts toys into a container (toy box)
[ ] Briefly stands by him/herself
[ ] Walks with one hand held
[ ] Uses thumb/finger to grab things
[ ] Says 'mama and dada" specifically to you
[ ] Says 2 other words besides mama/dada
[ ] Gives you an object when you ask for it
[ ] Helps getting dressed (lifting his arms)

Please check the boxes to indicate if your 15 month old does the following:

[ ] Drinks from a cup
[ ] Identifies body parts
[ ] Feeds self
[ ] Understands simple directions

Social:

- Are both parents living at home? ________
- Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? __________
- Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? _________
- There are concerns about firearms in the home ______

Screening – Please check the box if any of the following are true:

[ ] My child has had exposure to tuberculosis or a person with a positive skin test
[ ] My child spends a significant amount of time in a home built before 1960
[ ] There is a family history of high cholesterol of > 240 in either parent or grandparents
[ ] There is a family history of heart disease before 55 in either parent or grandparents
[ ] There is a family history of mental health concerns or substance abuse.

Vaccine Information Statements (Check One)

[ ] I will review the in-room copy
[ ] I will review the on-line copy at your website
[ ] I would like a paper copy