McLaren Medical Group

PEDIATRIC PHYSICAL EXAMINATION

AGE 12 Months

Date: _____ Age: _____ Accompanied By: _____

INTERVAL HISTORY / REVIEW OF SYSTEMS

See Pediatric/Adolescent History Form/Problem List/Med. List

Concerns/Additional History: _____

_____

_____

_____

_____

Nutrition: ☐ Breast ☐ Bottle ☐ Solid Foods _____

☐ Formula _____ ☐ Whole Milk

Amt/feeding _____ Frequency _____

Elimination: ☐ WNL _____

_____

Sleep: ☐ WNL _____

_____

Behavior: ☐ WNL _____

_____

Hearing: _____

Vision: _____

DEVELOPMENT

KEY:
☑ = Has achieved
☐ = Has not achieved

- ☐ Pulls to stand
- ☐ Vocabulary 1-3 words
- ☐ Walks with/without support
- ☐ Says mama/dada appropriately
- ☐ Attempts to stack cubes
- ☐ Pincher grasp mature

EDUCATION

Discussed and/or handout given:

- ☐ Nutrition
  - ☐ Milk
  - ☐ Introduction of New Foods
- ☐ Elimination
- ☐ Fever (Signs/Symptoms)
- ☐ Sleep
  - ☐ Sleep Disturbance
- ☐ Behavior/Development
  - ☐ Social - Separation Anxiety
  - ☐ Communication Skills - Read to Baby
  - ☐ Physical - Teething
  - ☐ Discipline Issues
- ☐ Injury Prevention
  - ☐ Auto/Car Seat
- ☐ Falls/Poison Control
- ☐ No Strings Around Neck
- ☐ No Shaking
- ☐ Burns
  - ☐ Water Heaters
  - ☐ Smoke Detectors
  - ☐ Carbon Monoxide Detectors
- ☐ Childproof Environment
- ☐ Tub Safety
- ☐ Firearm Hazards
- ☐ Passive Smoke Exposure
- ☐ Child Care
- ☐ Other: _____

_____

_____

PHYSICAL EXAMINATION

Weight _____ Height _____ Head Circumference _____

See Growth Chart

T: _____ P: _____ R: _____

KEY: ☑ WNL
☐ Not addressed or exceptions/abnormalities must be documented

- ☐ Gen. Appearance _____
- ☐ Head/Fontanel _____
- ☐ Eyes _____
- ☐ Ears _____
- ☐ Nose _____
- ☐ Mouth/Throat _____
- ☐ Lungs _____
- ☐ Heart _____
- ☐ Femoral Pulses _____
- ☐ Abdomen _____
- ☐ Genitalia _____
  - ☐ Male/Testes Down _____
  - ☐ Female _____
- ☐ Extremities _____
- ☐ Back _____
- ☐ Skin _____
- ☐ Neurologic _____

Comments: _____

_____

ASSESSMENT

☐ Well child

_____

_____

_____

_____

_____

_____

PLANS/FOLLOW-UP

_____

_____

_____

_____

_____

☐ Next well child at age 15 months

IMMUNIZATIONS

☐ Varicella Vaccine Date: _____ ☐ Chickenpox Date: _____ ☐ Prevnar #4
☐ Hep B #3 (if needed) ☐ Hib #4 ☐ IPV #3 (if needed)
☐ MMR ☐ Influenza Vaccine ☐ MCIR Updated
☐ Physician provided face-to-face counseling with the parent/guardian at the time of administration of (list number) _____ vaccine(s) at this visit.

SCREENINGS

☐ CBC
☐ Lead Screening Date: _____
☐ Lead Level Date: _____
PPD: ☐ Yes Date: _____ ☐ No

☐ Parent/guardian verbalized understanding of education/instructions
☐ See Progress Notes for additional documentation

Clinical Staff Signature: _____

Provider Signature: _____

Patient Name:

Date of Birth:

PEDIATRIC PHYSICAL EXAMINATION (12 Months)
MM-34301-G (10/07)